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Employees' Manual
Title 8
Chapter J

MEDICALLY NEEDY

Iowa
Department
of
Human Services

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OVERVIEW

This chapter provides information specific to the Medically Needy coverage group. Medically Needy provides Medicaid coverage to people who have too much income or resources to qualify for SSI cash assistance or for other medical coverage groups but not enough for medical care. These people must also meet categorical criteria for eligibility. That is, they must be:

- Aged, blind or disabled, or
- Members of families with children, or
- Pregnant women, or
- Children under age 21.

People eligible for the Medically Needy coverage group are eligible for payment for all services covered by Medicaid except:

- Care in a nursing facility, including a Medicare-certified skilled nursing facility or NF/MI.
- Care in an intermediate care facility for the mentally retarded.
- Care in an institution for mental disease.
- Rehabilitative treatment services for children (specified services in the family preservation, family-centered services, family foster care treatment, and group care programs).

The Medically Needy coverage group is authorized in Title XIX of the Social Security Act and described in the Code of Federal Regulations, Title 42, Chapter 4, Part 435. State authorization for the program is Iowa Code Chapter 249A. The portion of the Iowa Administrative Code dealing specifically with the Medically Needy coverage group is 441 IAC Chapters 75 and 76.

This chapter contains definitions for terms unique to the Medically Needy coverage group. You will also find descriptions of how people become eligible, the services for which they are eligible and other factors unique to Medically Needy, such as verifying medical expenses and the spenddown process.

Use this chapter in combination with Chapters 8-A, 8-B, 8-C, 8-D, 8-E, and 8-G to determine eligibility for the Medically Needy coverage group.

Definitions

Legal reference: 441 IAC 75.25(249A)

"Applicant" means a person for whom assistance is being requested, including at recertification.

"Break in assistance" means more than three months between the end of the last certification period and the beginning of the next certification period.

"Categorically eligible" means a person meets the broad guidelines for the categories of people to whom Medicaid eligibility is provided.

To be FMAP-related categorically eligible, a person would be a child under age 21, a parent living with a child under age 18, or a pregnant woman.

To be SSI-related categorically eligible, a person would be aged, blind or disabled.

"Certification period" is the time period for which a person may be determined eligible for Medically Needy. A conditionally eligible person is certified for a period of no more than two consecutive months. **Note:** Recipients with no spenddown have ongoing eligibility, instead of certification periods.

"CMAP (Child Medical Assistance Program)-related" refers to people under age 21 who are eligible for the Child Medical Assistance Program (CMAP) except for income and who do not qualify under the FMAP coverage group.

"Conditionally eligible recipient" is a person who is approved for Medically Needy with a spenddown but has not yet met the spenddown.

"Considered person" is a person whose needs, income, and resources are considered in the Medically Needy eligibility determination but who is not eligible to receive benefits.

"Dependent child" is a child who meets the non-financial eligibility requirements of the applicable FMAP-related coverage group.

"Eligible recipient" is a Medically Needy person with zero spenddown or who has met spenddown. This person has income at or less than the medically needy income level (MNIL) or has reduced income through the spenddown process to the MNIL.

"FMAP-related" means people who would be eligible for the Family Medical Assistance Program (FMAP) except for income or resources.

"Incurred medical expenses" are:

- Medical bills paid by a recipient, a responsible relative, or a state or by a political subdivision program (other than Medicaid) during the certification period or retroactive certification period, **or**
- Unpaid medical expenses for which the recipient or responsible relative remains obligated to pay.

"Medicaid-covered services" are medical services payable through the Medicaid program.

"Medically needy income level (MNIL)" is 133% of the FMAP schedule of basic needs (payment level) based on family size.

"Medically needy person" means a person who:

- Is FMAP-related or SSI-related,
- Has resources within the $10,000 limit, and
- Has income no more than the MNIL or has income reduced to the MNIL by spenddown.

"Medically Needy subsystem" is a subsystem of the Medicaid Management Information System (MMIS) managed by the Iowa Medicaid Enterprise (IME) that applies verified medical expenses against the unmet spenddown obligation and notifies the ABC system when spenddown has been met.

"Necessary medical and remedial services" are medical expenses recognized under state law that are currently covered by the Iowa Medicaid program.

"Obligated medical expenses" are expenses for which the recipient or responsible relative continues to be legally liable.

"Ongoing eligibility" means eligibility continues for people with a zero spenddown. There is no certification period.

"Recertification" means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Responsible relative" means a spouse, parent, or stepparent living in the household of the medically needy person. Responsible relatives are "considered" people.

"Retroactive certification period" is the period of up to three calendar months before the month in which a person applies for Medicaid. The retroactive certification period begins with the first month Medicaid-covered services are received and continues to the end of the month immediately before the month of application.

"Specified relative" is a person defined by FMAP policies. The specified relative must have a dependent child in their care.

"Spenddown" is the process in which a medically needy person obligates excess income for allowable medical expenses in order to reduce income to the household's MNIL.

"SSI-related" means aged, blind or disabled people who would be eligible for Supplemental Security Income (SSI) benefits except for excess income or resources.

PROCESSING MEDICALLY NEEDY APPLICATIONS

This section explains different or additional requirements for Medically Needy that do not apply to other coverage groups. Use the general guidelines provided in 8-B unless a unique requirement is listed in the following sections:

- Applications
- Recertifications
- Interviews
- Time limits
- Effective date of assistance
- Retroactive eligibility

Applications

Legal reference: 441 IAC 76.1(249A)

Use form 470-2927 or 470-2927(S), *Health Services Application*. See 8-B, Which Application Form To Use.

If it is necessary to determine Medically Needy eligibility for the period before a member's SSI eligibility was approved, use form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), *SSI Medicaid Information*, in place of an application. Follow procedures in 8-B, Collecting Eligibility Information From SSI Recipients.

Use form 470-2927 or 470-2927(S), *Health Services Application*, to determine eligibility for SSI-related Medically Needy when an SSI member becomes ineligible for SSI due to income or resources after the effective date of the SSI eligibility approval.

An applicant may withdraw the application for the month filed if the applicant wants to have the certification period begin the following month. Issue a *Notice of Decision* for the month the applicant withdrew. Process the application for the two following months.

> Mr. T files an application on October 28. When the IM worker contacts Mr. T, he states that he does not have any medical expenses for the month of October and requests that his certification period begin with the month of November.
>
> The IM worker issues a *Notice of Decision* stating that the client withdrew the application for October. The IM worker processes the same application for the certification period of November and December.

Recertifications

Legal reference: 441 IAC 75.1(35)"k," 76.1

Recertification is the process to establish a new certification period when the previous period has expired. The client must complete form 470-3118 or 470-3118(S), *Medicaid Review*, for recertifications.

Recertifications can be completed as long as there is no break in assistance (more than three months between the end of the last certification period and the beginning of the next certification period). If there is a break in assistance, the client must complete a new application to be recertified.

Note: Recertification is not done for people with ongoing eligibility, but an annual review is required.

Interviews

Legal reference: 441 IAC 75.1(35)"j"(2), 76.2(1)

Conduct interviews according to policy in 8-B, INTERVIEWS. It may be necessary to contact the applicant to explain the differences in the Medically Needy program policies for Family Medical Assistance Program (FMAP)-related, Child Medical Assistance Program (CMAP)-related, and Supplemental Security Income (SSI)-related coverage groups when a person would qualify under more than one coverage group.

If an applicant is ineligible for FMAP, provide the applicant an explanation of the Medically Needy program and process the application.

Ms. A, age 70, is approved for Medically Needy August 15. She continues to reapply every two months. The worker determines there is some information that needs clarified and schedules an interview. Ms. A informs her worker that her health does not allow her to go to the office.

As Ms. A does not have any family members or other representatives that can represent her at the interview, the income maintenance (IM) worker sets a time with Ms. A for either an interview by telephone or a home visit.

Program Information

Legal reference: 42 CFR 435.905, Iowa Code Chapters 217 and 249A

In addition to the requirements listed in 8-B under INTERVIEWS, you must also explain either orally or in writing the following to clients, prospective clients, and anyone asking about the Medically Needy program:

- The definition of "conditionally eligible" and "responsible relative."
- The use of the income and resources of all conditional eligibles and responsible relatives to determine eligibility.
- Resource guidelines.
- The Medically Needy income level.
- The spenddown process and the medical expense verification form.

Time Limit for Eligibility Decision

Legal reference: 441 IAC 76.3(1)

The applicant must receive a written notice of approval, conditional eligibility, or denial as soon as all information is available, but no later than 45 days from the date of application. When you are determining eligibility for other coverage groups at the same time as Medically Needy, the normal 30-day guideline still applies for those other groups.

Extend the notice deadline to 90 days from the date of application if an SSI-related applicant applies for benefits based on blindness or disability and a disability determination has not yet been made. See 8-B, PROCESSING STANDARDS, for what to do if the determination exceeds 90 days.

Follow the guidelines in 8-B, PROCESSING STANDARDS, regarding the extension of the time limit for sending a *Notice of Decision* when the applicant and county office make every reasonable attempt to obtain the necessary information and conditions exist that are beyond their control.

Effective Date of Assistance

Legal reference: 441 IAC 75.1(35)"g"(3), 76.5(2)"a"

Eligibility begins on the first day of the first month of the certification period in which the client's income is reduced to the Medically Needy income level or the client was determined to have ongoing eligibility.

Enter all Medically Needy applications onto the Automated Benefit Calculation (ABC) system. Cases that are approved and have zero spenddown in the retroactive certification period or have ongoing eligibility are maintained by the ABC system and are not passed to the Medically Needy Subsystem. People with active fund codes are automatically eligible for Medicaid.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy Subsystem. When the spenddown obligation is met, the Medically Needy Subsystem issues a *Notice of Spenddown Status* (NOSS).

Retroactive Eligibility

Legal reference: 441 IAC 75.25, 76.5(1)

A client may be eligible for retroactive Medically Needy benefits for a period of one, two, or three months preceding the month when the application was filed. The applicant does not need to be eligible in the month of application to be eligible for the retroactive period. To be eligible for retroactive benefits, the applicant must meet **both** of the following:

- Have incurred medical expenses for Medicaid-covered services that were received during the retroactive period. These expenses may be paid or unpaid.
- Would have been eligible for Medicaid benefits in the month services were received if application had been made (even if the applicant is not alive when the application is filed).

The retroactive certification period begins with the first of these three months in which the client received Medicaid-covered services. It continues to the end of the month immediately before the month of application.

Exclude from the Medically Needy certification period any month in which the client received Medicaid or if the applicant would have been eligible for Medicaid under another coverage group. (See Eligibility Under Another Coverage Group.)

Mrs. Z applies for Medically Needy for her family on September 19. They have previously received FMAP January through June. Mrs. Z has paid for medical services that she incurred in July. She has an unpaid medical bill for services her daughter received in August. The retroactive period for Medically Needy is established for only two months, July and August.

May	June	July	August	September	October
FMAP	FMAP	Retroactive period for Medically Needy		Current certification period	

If there are medical expenses for Medicaid covered services (either paid or unpaid) in any month of the retroactive period, complete a spenddown calculation. If there are no medical expenses in all months of the retroactive period, you do not need to do a spenddown calculation.

Mrs. J applies for Medicaid May 4 and requests retroactive eligibility. She paid a medical bill on March 15. The medical expense was for Medicaid-covered services received in January. Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

Retroactive eligibility is denied, because Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

See INCOME POLICIES: Income and Spenddown in the Retroactive Period for more information on calculating spenddown.

Eligibility Under Another Coverage Group

Retroactive periods may involve eligibility determinations for several coverage groups. Therefore, before determining Medically Needy eligibility, establish that the applicant is ineligible for all other Medicaid coverage groups. The ABC system typically is the mechanism for making determinations for other coverage groups. Send form 470-0397, *Request for Special Update*, to Quality Assurance (QA) to update the Medicaid eligibility file in the following situations:

- Situation: The state ID does not show on SSNI. The client is eligible for Medically Needy in the current month or for ongoing eligibility and is eligible for the retroactive months under another coverage group. Enter the Medically Needy case on ABC. After ABC updates, send Quality Assurance a *Request for Special Update* for the retroactive months that are under another coverage group.
- Situation: The state ID does not show on SSNI. The client is not eligible for the month of application or ongoing eligibility, but is eligible for retroactive Medicaid. Process the denial for the current or ongoing eligibility on ABC. In this situation, QA builds an SSNI file for the retroactive months. QA needs the following to build an SSNI file:
  - Memo with all case and individual information.
  - *Request for Special Update* showing the aid type and months in which eligibility exists.

- Situation: Ongoing Medicaid eligibility does not exist. An individual eligibility record exists on SSNI. Enter retroactive periods that involve another coverage group and a Medically Needy zero spenddown period via the *Request for Special Update*.

Ms. T, age 32, applies for Medically Needy on October 6 for herself and child A, age 10. She reports unpaid bills for Medicaid-covered services received in July and August. She has never received Medicaid before. The worker determines Ms. T's eligibility in the retroactive period as follows:

July	**August**	**September**
Eligible for retroactive FMAP	Retroactive eligibility for Medically Needy	Retroactive eligibility for Medically Needy

Ms. T is eligible for retroactive Medicaid through the Family Medical Assistance Program (FMAP) coverage group for July if unpaid or paid medical expenses exist for Medicaid-covered services received in July.

The Medically Needy retroactive period is August and September, even though unpaid medical expenses exist only in August. July's income is not included in the Medically Needy retroactive period, since eligibility existed under another coverage group (FMAP).

Ms. T has a spenddown for the August-September Medically Needy retroactive period.

Her state ID does not show on the SSNI screen, since she has never received Medicaid. Therefore, Quality Assurance cannot enter her July Medicaid eligibility through a *Request for Special Update*.

The worker first opens Ms. T's case on ABC with the FMAP aid type, reflecting income of the family on the BCWs for the months of July, August, and September for the retroactive period, the month of application, and future months, as required.

Once ABC has processed this information, the worker enters Medically Needy eligibility information in the ABC system for the August-September Medically Needy retroactive period.

DETERMINING THE COVERAGE GROUP

Legal reference: 441 IAC 76.1(249A); 83.2(1)"b"

Screen the application to determine if there are other Medicaid coverage groups for which the client would be eligible, including State Supplementary Assistance dependent person. (The income limits of the dependent person coverage group are higher than the MNIL.) Document in the case record that the application was screened for other coverage groups.

Do not grant Medicaid eligibility under Medically Needy if the person could be determined eligible under another coverage group.

When determining if a person is eligible under another coverage group, consider whether the person is eligible for SSI. If a person who would be eligible for SSI wants to apply for cash assistance and Medicaid, refer the person to the Social Security Administration to apply for SSI benefits.

See the following sections for more information on:

- Groups who are eligible for Medically Needy.
- Who is not eligible for Medically Needy.
- People who are concurrently eligible under Medically Needy and also under QMB or SLMB.

Who Is Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75.1(35)"a;" 83.2(1)"b"

The Medically Needy coverage group is available only to people who are not eligible under other Medicaid coverage groups because of excess income or resources.

People eligible for the Medically Needy coverage group are:

- Children under the age of 21 who would be eligible for FMAP, CMAP, or SSI except that their income exceeds the limits.
- Relatives caring for a dependent child who have income or resources exceeding the FMAP limits and who meet the FMAP definition of specified relative.
- Pregnant women over income limits for MAC.

- Pregnant women not eligible for continuous eligibility for pregnant women.
- Women in the postpartum period.
- Newborn children of Medically Needy Medicaid-eligible mothers.
- Persons who are aged, blind, or disabled and who would be eligible for SSI except that their income or resources exceed the limits.

Residents of residential care facilities (RCFs) whose income is over the State Supplementary Assistance limits are eligible through the Medically Needy coverage group if they are categorically eligible, e.g., under 21, pregnant, aged, blind, or disabled. The Medically Needy coverage group does not pay for RCF care, but it does pay for other Medicaid-covered services the client receives if spenddown is met.

Applicants have the choice whether to have eligibility determined as SSI-related, FMAP-related, or CMAP-related, if the person would qualify under more than one group.

Household composition: Mr. and Mrs. S and their child, Sarah, age 13.
Mr. S is employed full time and earns $4,000 per month. Mrs. S is legally blind and works part time for the Blind Commission. She earns $500 per month and receives $2,100 social security disability benefits. The household is over income for FMAP. Mrs. S is not income-eligible for SSI and is over income for MEPD. The application is processed for Medically Needy.
The worker determines whether it is to Mrs. S's advantage to be SSI-related or FMAP-related in determining eligibility.
SSI-related: Follow the procedures for deeming income from a spouse (see 8-E). FMAP-related: Include Mrs. S's income and treat according to FMAP policy. If it is to Mrs. S's advantage to be treated as SSI-related, Mrs. S remains a considered person on the FMAP-related case, since she is a parent. If Mrs. S is on the SSI-related case, she cannot be excluded from the FMAP-related case. Mrs. S's medical bills would be used to meet spenddown on both cases. (See SSI-Related, FMAP-Related Composite Households later in this chapter.)

Who Is Not Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75.1(35)"a"; 83.2(1)"b"

A person is not eligible for the Medically Needy coverage group if the person is eligible for another coverage group, with **two exceptions**:

- A client does not have to apply for any home-based or community-based services waiver to be eligible for the Medically Needy program. Allow a client who is eligible for either the Medically Needy coverage group or a waiver program to choose in which program to participate. Certain waivers allow Medically Needy coverage group when the person needs hospital level.
- A client may receive Medicaid under the qualifying Medicare beneficiary coverage group or the specified low-income Medicare beneficiary coverage group and be concurrently eligible for the Medically Needy coverage group. (See Concurrent Eligibles.)
- A person who qualifies both for Medicaid for employed people with disabilities (with or without a premium) and for Medically Needy (with or without a spenddown) may choose which coverage group eligibility is established under. (See 8-F, Medicaid for Employed People with Disabilities: Relationship to Medically Needy.)

A person with income less than FMAP-related limits or SSI limits (depending on the coverage group under which the person would be eligible) is not eligible for the Medically Needy coverage group unless resources exceed other Medicaid program limits.

If a person who would be eligible for SSI wants only Medicaid and not cash assistance, grant Medicaid eligibility under the coverage group for persons eligible for but not receiving SSI or SSA cash benefits -- not under the Medically Needy coverage group.

Concurrent Eligibles

Legal reference: Social Security Act, Sections 1902(a)(10)(E)(iii) and 1905(p)(1)

Clients who meet the eligibility requirements for qualified Medicare beneficiary (QMB) or specified low-income Medicare beneficiary (SLMB) may also be concurrently eligible for Medically Needy.

Expanded specified low-income Medicare beneficiaries (E-SLMB) may also be determined conditionally eligible for Medically Needy.

Note: Clients who are eligible for E-SLMB are not eligible for other Medicaid coverage groups. If a client who has been determined eligible for E-SLMB meets spenddown for Medically Needy, the Medicare Part B premium will be paid for as a Medically Needy recipient. However, do not cancel the client's E-SLMB case when the client meets spenddown.

QMB and SLMB clients who are concurrently eligible for Medically Needy and E-SLMB clients conditionally eligible for Medically Needy must have two cases:

- One case with a QMB, SLMB, or E-SLMB aid type (90-0, 90-1, or 92-0).
- A second case with a 37-E aid type.

NONFINANCIAL ELIGIBILITY

Most nonfinancial eligibility requirements for Medically Needy eligibility are comparable to those of the underlying categorical eligibility groups. Exceptions and explanations of how these requirements apply in Medically Needy cases are included in the following sections:

Determining the Eligible Group

Legal reference: 441 IAC 76.2(2)

Medically Needy households may include members who are FMAP-related, CMAP-related and SSI-related. Each categorically related Medically Needy coverage group requires that certain household members be included in or excluded from the eligible group.

For any coverage group, exclude from the Medically Needy eligible group:

- People receiving FMAP or SSI. Do not count their income in the Medically Needy spenddown calculation. A "1619b" person is considered an ineligible spouse. The 1619b person has medical coverage under the SSI coverage group. See 8-F, People Ineligible for SSI (or SSA): Due to Earnings Too High for an SSI Cash Payment (1619b Group).
- An unlawful alien who is not categorically eligible.

For SSI-related households, establish an eligible group for a spouse who enters a medical institution expecting to stay 30 or more days and another eligible group for the community spouse. Refer to 8-I, INCOME AND RESOURCES OF MARRIED PERSONS.

When determining the eligible group for FMAP/CMAP-related Medically Needy:

- Follow the guidelines listed in Chapter 8-C, NONFINANCIAL FMAP-RELATED ELIGIBILITY: Eligible Group.
- Determine which members must be included or excluded.
- Include in the household size those people in the household who are:
  - Categorically eligible under FMAP/CMAP-related Medically Needy.
  - Any additional people required to be considered.
- Remove any household members who are voluntarily excluded.
- Do not include in the Medically Needy eligible group:
  - A stepparent who is not the parent of any of the children living in the household unless the stepparent is incapacitated or needed to care for the children in the home. See Household With a Stepparent.

- A legalized alien who is a considered person for the eligible group but is not categorically eligible.
- An unlawful alien who is a considered person for the eligible group and is categorically related **unless an emergency medical service is needed**.

An adult alien who is ineligible for Medicaid, but is a "considered" person, is included in the household size.

When the household requests to add the voluntarily excluded person to the eligible group that has been certified, the voluntarily excluded person is not eligible until the month following the month of the request.

Voluntarily excluded people are **not** considered as responsible relatives. When a person is voluntarily excluded from the Medically Needy household, do not use that person's paid or unpaid medical expenses in meeting the household's spenddown.

1. The household consists of Mr. A, 60, and Mrs. A, 65. Mr. A receives Medicaid through in-home health-related care (IHHRC) program, but does not receive SSI. Mrs. A applies for SSI-related Medically Needy.

   Mr. and Mrs. A are both in the Medically Needy household. Mr. A is a responsible relative (he has income deemed to Mrs. A). Mrs. A is eligible or conditionally eligible individual. If a spenddown exists, Mr. A's IHHRC client's participation is an allowable medical expense in meeting Mrs. A's spenddown.

2. Household composition:
   Ms. M (who is not disabled or over 65)
   Ms. M's 20-year-old daughter (who is not pregnant)
   Ms. M's 4-year-old grandson (who is not the daughter's child)

   Ms. M has $460 VA benefits, the daughter has no income, and the grandson receives $1,500 from a trust. The household applies for Medically Needy on January 10. All household members request Medicaid eligibility for this certification period.

   The daughter is ineligible for CMAP, since Ms. M's income exceeds the standard for a two-member household (Ms. M and her daughter).

   The grandson is ineligible for CMAP, since his income exceeds the CMAP standard for a one-person household, and for MAC, since his income exceeds 133% of the poverty level for a one-person household.

   Ms. M is considered as the needy relative of the grandson, since she is requesting Medicaid coverage for herself. This ties Ms. M to the other two people in the household. Ms. M cannot be separated by policy from either person and still receive Medicaid coverage. But she could voluntarily exclude the grandson and still receive Medicaid for herself as long as she is needy.

   For Medically Needy, the household is a family of three. The spenddown calculation combines Ms. M's income and the grandson's income and compares the result to the MNIL for a three-member household.

3. The M Household in Example 2 applies for recertification on February 15. On February 10, the daughter began employment and is projected to receive $400 in monthly earnings beginning in March. Since the daughter has no anticipated medical expense, Ms. M requests a Medicaid determination only for herself and her grandson.

   The spenddown calculation now compares the same income to the MNIL for a two-member household, resulting in a larger spenddown.

4. The household consists of Mr. T, age 41, and his children, Tom, age 20; Tim, age 15; and Ted, age 10. Mr. T is employed full time. After the 20% earned income deduction, his monthly net income is $2,500. Mr. T is over income for FMAP and other Medicaid coverage groups. His application is processed for Medically Needy.

   Tom is also employed. Mr. T can voluntarily elect to exclude Tom, who is CMAP-related, and request Medicaid eligibility only for the FMAP-related household members. However, if Tom is voluntarily excluded, he cannot receive Medicaid under any other coverage group.

5. The household consists of Mr. and Mrs. Q and their children, K, age 20, X, age 10, and Y, age 5. The household is over income for FMAP. Child K has no income or resources. Since Mr. and Mrs. Q are not on FMAP, they are considered self-supporting parents and their income is used to determine eligibility for all of their children.

   The Qs' income is within the income limits for a household size of four for MAC. X and Y receive Medicaid coverage under MAC.

   The Medically Needy household size is five. Mr. and Mrs. Q and K are conditionally eligible. X and Y are considered persons on the case.

People Who Have a Choice of Coverage Groups

Legal reference: 45 CFR 435.404, 441 IAC 76.2(2)

A person in the FMAP-related household who could also be SSI-related has a choice of being FMAP-related or SSI-related. Explain program guidelines of the options available, so the client can decide what is best for the household.

If a person in the household could be eligible as either FMAP-related or SSI-related, allow the client to choose under which program to be considered based on:

- The amount of spenddown for each case.
- Which family members usually incur medical bills.
- Which family members have unpaid bills incurred before the certification period.

If a client chooses to be FMAP-related, establish one case for all FMAP-related household members. If the household chooses for some of the members to be SSI-related, establish an SSI-related case and an FMAP-related case with separate FBUs. For more information on calculating spenddown in these cases, see INCOME POLICIES: SSI-Related, FMAP-Related Composite Households.

The household composition is Mr. and Mrs. J, Child A (SSI-related), and Child B (FMAP-related). The Js made the choice to have Child A considered as SSI-related rather than as FMAP-related. If the Js want Medicaid for both children, there will be an SSI-related case and an FMAP-related case.

The SSI-related case is a one-person household for Child A. The parents' income is used to determine eligibility following SSI policy. The parents are not responsible relatives on the SSI-related case. (**Note:** Following SSI policy, the parents receive a living allowance as a deduction.)

The FMAP-related case is a four-person household for Child B, Mr. and Mrs. J, and Child A, as a considered person on the case.

If the parents want Medicaid only for Child A, there will be an SSI-related case with a household size of one. **Note:** The Js may apply later for Child B as an FMAP-related child. If they do, Child A has to be included as a considered person on Child B's FMAP-related Medically Needy case.

If the parents want Medicaid only for Child B, there will be a CMAP-related case with the parents as responsible relatives with a household size of three. (Child A is excluded and there would not be an SSI-related case.)

FMAP-Related Medically Needy

Legal reference: 441 IAC 75.1(35)"a," 75.14(249A)

Use the following FMAP policies to determine a client's eligibility for the FMAP-related Medically Needy coverage group when resources or income exceeds FMAP limits:

- Specified relative.
- Income, but not the FMAP income limits or the 58% work incentive deduction.
- Liquid resources, but not the nonliquid resource policies or resource limit.

Assignment of medical support is required. See 8-C, Failure to Cooperate in Obtaining Support.

FMAP-related specified relatives and their children may be eligible or conditionally eligible members of the Medically Needy household. Specified relatives are defined in 8-C, Specified Relatives, as parents, or stepparents of dependent children. Specified relatives must be over income or resources for FMAP to be eligible for Medically Needy.

The FMAP-related specified relative must have a child in the household. However, the child does not need to be included in the Medicaid-eligible group for the parent to be eligible or conditionally eligible for Medicaid. The family may choose to voluntarily exclude the child of a specified relative.

For FMAP-related Medically Needy applications or automatic redetermination:

- First consider eligibility for all other FMAP-related Medicaid coverage groups.
- If the case is not eligible under any FMAP-related coverage group, examine the children's eligibility for Medicaid under the FMAP-related Medically Needy coverage groups and refer to Health and Well Kinds in Iowa (***hawk-i)***.

Complete an automatic redetermination for the Mothers and Children (MAC) or Medically Needy coverage group when transitional medical ends for an FMAP case.

An FMAP-related Medically Needy household may consist of people under different coverage groups such as:

- One or more children on MAC.
- One or more children on Medically Needy.
- Pregnant woman on MAC.
- Parents on Medically Needy.

1.	Household composition is Ms. J, age 25, and her children, Jimmy, age 6, and Jill, age 5. Ms. J is employed full time. She applies for FMAP. After deductions for the 20% earned income deduction, child care, and the 58% work incentive deduction, Ms. J's net income exceeds the FMAP income limit.
	Ms. J is over income for FMAP, and other Medicaid coverage groups. Her application is processed for FMAP-related Medically Needy. For Medically Needy, Ms. J does not receive the 58% work incentive deduction and her net income is $1,080. The children are both eligible for MAC. Ms. J is conditionally approved for Medically Needy.
2.	The household consists of Mr. and Mrs. E and their two children, ages 2 and 4. The family applies for Medicaid on July 7. Mr. E works and the household is determined to be over income for FMAP. The children are determined to be eligible for MAC. Mr. and Mrs. E are conditionally eligible for Medically Needy for July and August.

See the following sections for more information on:

- FMAP-related nonparental relatives.
- CMAP-related Medically Needy.

FMAP-Related Nonparental Relative

Legal reference: 441 IAC 75.1(35)"a," 75.14(249A)

Only one needy specified relative can be a member of the Medically Needy household. See 8-C, Who May Be in the FMAP Eligible Group, for more explanation of needy specified relative.

A child living with a needy specified relative may qualify for FMAP based on the child's income. If the needy specified relative's income and resources exceed the limits for the needy specified relative to qualify for FMAP, determine eligibility for FMAP-related Medically Needy.

When the needy specified relative is over income or over resources for FMAP, consider income for a needy specified relative using FMAP policies, but do **not** allow the 58% work incentive deduction.

Divert the income of the needy specified relative to other members of the household using the FMAP Schedule of Basic Needs. The needy specified relative's spouse and children are responsible relatives and need to be on the ABC system.

The child can be on the Medically Needy case if the child's income exceeds FMAP limits or the MAC limit.

Household composition: Mr. and Mrs. H and their grandson.

Mr. H has income of $1,000 unemployment insurance benefits, and Mrs. H has income of $350 unemployment insurance benefits. Their grandson is eligible for CMAP and receives FIP. When this household applies, they request that Mrs. H be considered for FMAP "needy specified relative" and for Medicaid because she is experiencing health problems.

Mrs. H is not disabled or aged. Her eligibility for FMAP is calculated as follows:

$ 1,000.00	Mr. H's UIB
+ 350.00	Mrs. H's UIB
$ 1,350.00	Total gross income

The $1,350 total gross income exceeds 185% of living costs for a household of two ($1,330.15). Therefore, there is no eligibility for FMAP for Mrs. H as a needy specified relative.

The next step is to determine eligibility under the Medically Needy coverage group as follows:

$ 1,350.00	Gross income for Mr. and Mrs. H
- 183.00	Diversion for Mr. H (Schedule of Basic Needs for 1)
$ 1,167.00	Monthly countable income considered as available to Mrs. H
$ 2,334.00	$1,167 income × 2 months
- 966.00	$483 MNIL (for Mrs. H only) × 2 months
$ 1,368.00	Spenddown

Mrs. H is entered on the ABC system as a Medically Needy FMAP-related specified relative. Mr. H is entered as a responsible relative. The grandson is not part of the Medically Needy household because he receives FIP.

CMAP-Related Medically Needy

Legal reference: 441 IAC 75.1(35)"a"

Apply FMAP eligibility policies to determine if a person is eligible for the Medically Needy coverage group as CMAP-related, **but do not apply the following policies**:

- Age under 18 (19 for some students).
- Living with a "specified relative."
- Participating in a strike.
- Receiving the 58% work incentive deduction.
- Counting nonliquid resources.

Parents in CMAP-related households are responsible relatives for the Medically Needy coverage group. See 8-F, Child Medical Assistance Program (CMAP), for more information about CMAP coverage.

Include the CMAP-related child with the child's parents on a Medically Needy case if the parents are FMAP-related.

1. Mr. C, age 20, and Mrs. C, age 19 and pregnant, apply for Medicaid. Mr. C is employed full time. After the 20% work expense deduction, his monthly net income is $3,000. Mr. and Mrs. C may be CMAP-related as they are under 21.

   The unborn child is considered in determining household size. The Cs are over income for CMAP. Mrs. C is also over income for MAC. The application is processed for CMAP-related Medically Needy. NOTE: If the Cs can meet their spenddown, they are not eligible for IowaCare.

2. Household composition: Mr. and Mrs. D and Mrs. D's 21-year-old daughter and 19 year-old son by a previous marriage. Mrs. D is applying for Medicaid for her son. Both Mr. and Mrs. D have income. Mrs. D chooses to exclude the stepfather's income.

   The son is over income for CMAP. The income of Mrs. D and her son is used to determine the spenddown amount for a CMAP-related Medically Needy case. The household size is one because Mrs. D chose to exclude Mr. D's income from use in determining the spenddown and therefore must also exclude herself. Mr. and Mrs. D are not eligible for IowaCare, as Mr. D's income was excluded.

Pregnant and Postpartum Women and Newborns

Legal reference: 441 IAC 75.1(35)"a"

Pregnant women are eligible for Medically Needy when they would be eligible for FMAP-related Medicaid (including MAC or CMAP) or SSI-related except that income or resources exceed limits. See 8-F for FMAP-related and SSI-related coverage groups.

Household composition: Mr. Z, age 27, and Mrs. Z, age 31, pregnant. Mrs. Z applies for Medicaid. Mrs. Z is employed full time. Mr. Z is not employed.

After deductions for work expenses, Mrs. Z's net income exceeds 200% of the federal poverty level. Since she is over income for MAC coverage, her application is processed for FMAP-related Medically Needy. NOTE: If Mrs. Z can meet spenddown, she is not eligible for IowaCare. Mr. Z is not conditionally eligible for Medicaid and could apply for IowaCare.

Do not put a pregnant woman on Medically Needy when she becomes over income for a Medicaid coverage group. The pregnant woman remains continuously eligible for Medicaid through the pregnancy and postpartum period without regard to any changes in family income. See 8-F, Continuous Eligibility for Pregnant and Postpartum Women.

The Medically Needy coverage group continues to be available for the 60-day postpartum period. The postpartum period begins with the last day of pregnancy and continues through the last day of the month in which the sixtieth day falls. Spenddown must be met for the woman to be eligible for the postpartum period. Spenddown can be met after the pregnancy ends.

An application may be required for the postpartum period if the woman's certification period expires before the postpartum period ends.

Household composition: Mrs. F, age 25, pregnant, and Mr. F, age 29, works full-time
Mrs. F is currently receiving Medicaid under the Medically Needy program for an October-November certification period. The baby is born October 15. Mrs. F continues to remain eligible for Medicaid for November.
Mrs. F must reapply for Medically Needy if she wants to continue to receive postpartum eligibility for December, because her certification period has expired. She must meet spend-down for the new certification period, if applicable, before receiving Medicaid under the postpartum coverage group for December.

Medicaid is available to newborn children if:

- The mother establishes eligibility for the month of the child's birth under an FMAP-related or SSI-related coverage group, including three-day emergency services; and
- The baby lives with the mother.

Newborn coverage begins with the month of the birth and extends through the month of the child's first birthday, if the child lives with the mother and the mother:

- Remains eligible for Medicaid,
- Meets the spenddown for each certification period, and
- Would be eligible for Medicaid if she were still pregnant.

For Medicaid-only coverage groups, an application is not required for the newborn as long as the mother remains eligible. However, if the mother's Medicaid has ended (e.g., end of a certification period), she must complete a new application for recertification for herself and the newborn if she wants to continue receiving Medicaid coverage.

SSI-Related Medically Needy

Legal reference: 441 IAC 75.3(249A), 75.1(35)"a"

To be eligible for the Medically Needy coverage group as SSI-related, the client must meet the SSI criteria for age, blindness or disability. The person must also be over income or over resources for SSI and other SSI-related Medicaid coverage groups.

Applicants with income and resources less than the SSI standard or those who have applied for SSI and are waiting for an eligibility decision are **not** eligible for the SSI-related Medically Needy coverage group. Determine if eligibility exists under one of the other SSI-related coverage groups.

> A married couple has income greater than the MNIL for a couple but less than the SSI benefit for a couple. This means the couple is not covered under Medically Needy. The worker examines eligibility under SSI-related coverage groups, such as State Supplementary Assistance dependent person.

Age Criteria

Legal reference: 441 IAC 75.1"a"(4)

To be eligible for SSI-related Medically Needy as an aged person, the applicant must be age 65 or older. See 8-C, Presence of Age, Blindness, or Disability, for more detailed information about the SSI or social security criteria for age.

Blindness Criteria

Legal reference: 441 IAC 75.1(35)"a"(4)

To be eligible for SSI-related Medically Needy as a blind person, the applicant must meet the SSI or social security criteria for blindness. See 8-C, Establishing Blindness, for detailed information.

A state disability determination may need to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has been denied social security (Title II) benefits only (not SSI) by the Social Security Administration as not disabled due to blindness, or
- Is in the process of applying for benefits.

Disability Criteria

Legal reference: 441 IAC 75.25(249A), 75.1(34)"a"(4)

To be eligible for SSI-related Medically Needy as a disabled person, the applicant must meet SSI or social security criteria for disability. See 8-C, Establishing Disability, for detailed information.

To be eligible for SSI-related Medicaid based on disability, a person must be unable to engage in any "substantial gainful activity" because of a physical or mental impairment. (See 8-C, Department Disability Determination Process, for more information.) The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

People are considered disabled when they receive Title II (social security disability) benefits or receive Railroad Retirement benefits that were based on the same criteria that the Social Security Administration uses to determine social security disability.

For Medically Needy, the Department is required to follow federal Social Security Administration decisions on disability for **SSI** with certain exceptions on denials by the Social Security Administration.

Always determine the status of any Social Security Administration activity before processing applications based on disability, regardless of the coverage group for which the person is applying. Possible statuses are:

- The person did not apply with Social Security for benefits.
- Benefits have been approved.
- An application for benefits is pending.
- An application for benefits has been denied. See When a Client Has Been Denied SSI Disability Benefits.

Based on Social Security Administration activity, either:

- Approve or deny Medicaid benefits.
- Request a separate disability determination. See 8-C, Department Disability Determination Process.

A state disability determination needs to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has not been determined disabled by the Social Security Administration.
- Has applied for social security disability benefits and a decision hasn't been made.
- Is in the process of appealing an earlier denial of social security disability benefits.
- Has been denied by the Social Security Administration for social security disability (Title II) as not disabled. **Note:** Medically Needy **cannot** rely on a Title II denial, but must do an independent determination.

To determine disability, obtain form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*, completed by the applicant or the applicant's representative. Also obtain one form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Department of Human Services.* For more information on these forms, see 6-Appendix.

Send all reports and authorizations to DDS along with form 470-2472, *Disability Transmittal*, which is a cover memo to help DDS in determining disability.

When a Client Has Been Denied SSI Disability Benefits

Legal reference: 42 CFR 435.541, 441 IAC 75.20(2)"a"

Check the State Data Exchange's SDXD screen for an SSI denial or approval when you receive a Medicaid application based on disability. If there has been a disability denial, check the appeal coding to determine if an appeal has been denied. A denial based on disability is an indication that the applicant is not over income or over resources, and therefore does not qualify for Medically Needy.

If a person has been denied SSI benefits based on disability, check to see if the decision is final. (See 8-C, Social Security Administration Appeal Process, for an explanation of the SSA appeal process.) A Social Security decision is final when:

- The person has gone through the full Social Security appeal process, been denied at all levels, and cannot go further in the Social Security system; OR
- A denial was made at any level of the Social Security appeal process and the person did not appeal to the next level within 65 days.

If the decision is not final, deny the application based on the SSI denial.

If the decision is final, determine if the person has a different condition than that considered by the Social Security Administration. Request a copy of the denial explanation from the applicant. Compare the information on the denial explanation to the information on the *Health Services Application*, form 470-2927 or 470-2927(S).

If there is a different condition that is expected to last 12 months, do a disability determination. See 8-C, Department Disability Determination Process. If there is no different disabling condition, check if 12 months have passed since the final decision.

If 12 months have passed and the person alleges a change or deterioration in the disability that is expected to last 12 months, do a disability determination. See 8-C, Department Disability Determination Process. If the condition has not changed or deteriorated, and the person does not claim a new 12-month period of disability, deny the application based on the SSI decision.

If a decision has not been final 12 months, and the person claims the condition has worsened and claims a new 12-month disability period, ask the following questions:

- Has the Social Security Administration refused to reconsider the claim on the worsening of the condition?
- Does the person no longer qualify for SSI based on nondisability requirements, but qualifies for Medicaid based on nondisability requirements?

If the answer to either of these questions is "yes," complete a disability determination. If both answers are "no," deny the application based on the SSI decision and refer the person to the Social Security Administration.

Disability Determination on Reapplication

Legal reference: 441 IAC 76.1(35)"l"

When a client reapplies for SSI-related Medically Needy based on disability, disability is redetermined as follows:

- If the client is currently receiving social security disability benefits, no further disability determination is required.

- If the Department determined the person's disability, no further disability determination is required unless reexamination is specified in the original disability determination.

  A new determination is not necessary if the person alleges that the condition has not changed (improved), and DDS has not established a review for the time that the person was canceled.

- When reexamination was specified in the original disability determination, send DDS:

  - A current form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*.
  - A current form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Department of Human Services*.
  - A current form 470-2472, *Disability Transmittal*.
  - All appeal documents (if eligibility is gained through a successful appeal of disability).

- If a person reapplies for Medicaid following rejection or cancellation based on a Department disability decision and alleges no change, deny the application on the basis of not meeting disability requirements.

RESOURCE POLICIES

Legal reference: 441 IAC 75.1(35)"b," 75.1(35)"c"

Count the resources of all responsible relatives and all eligible or conditionally eligible people living together. The resource limit for Medically Needy households is $10,000.

Disregard all liquid resources of all responsible relatives and all eligible or conditionally eligible people living together when determining eligibility for FMAP-related children.

FMAP-related people are resource-eligible if their resources are determined to be within the resource limits any time during the month before the eligibility is determined.

For FMAP-related households, count liquid resources such as:

- Cash.
- Checking and saving accounts.
- Stocks, bonds, and certificates of deposit.
- The available principal of Medicaid qualifying trusts.

Exempt for FMAP-related households:

- Retirement plans as defined by the Internal Revenue Service, such as:
  - IRAs.
  - Keoghs.
  - 401Ks.
  - 457 plans.
  - Deferred compensation accounts.
  - IPERS.
- Annuities.
- Bank accounts solely used for a self-employed person's business.

Do not count nonliquid resources for FMAP-related households.

Disregard the resources of all responsible relatives and eligible or conditionally eligible people living together when determining eligibility for SSI-related children.

Count resources of a SSI-related person as of the first day of the month. Treat the resources of SSI-related households according to SSI policy. (See Chapter 8-D, *RESOURCES*.)

For all clients, count only the unobligated balance of a checking account. The unobligated balance is the balance listed in the checking account as of the date of decision for FMAP-related clients. Subtract any checks that have been written, as indicated on the register or by the client. Use the balance as of the first moment of the first day of the month for SSI-related clients.

Use the "prudent person" concept to determine whether to use the checking account register or to verify the balance with a financial institution. If the verified balance combined with other resources is close to the limit, you may verify any checks the client claims to have written. Request that the client provide receipts showing payment made, canceled checks or obtain a release of information for the person to whom the check was written.

Follow Medicaid policies in 8-D, TRANSFER OF ASSETS, if assets were disposed of for less than the fair market value.

Examine Medically Needy eligibility when a household is ineligible for FMAP or as an SSI recipient because of available resources from a trust.

If the available resources from the trust exceed $10,000, deny. If the available resources from the trust are $10,000 or less, include them with other resources to determine resource eligibility. Also count the beneficiary's income, including income from the trust to determine the amount of the spenddown.

1. Mr. and Mrs. K and their two children apply for Medically Needy on July 10. Mr. K is disabled and asks to be considered an SSI-related person. Mrs. K is considered an FMAP-related person because the family asks for Medicaid for the children.

   Mr. and Mrs. K have a joint savings account. On July 29, the date of decision, the account balance is $1,000. As of July 1, the account had a balance of $22,000. Mr. K has a money fund account with a balance of $2,000 on July 1 and July 29.

   Mr. and Mrs. K's resources of $24,000 exceed the $10,000 resource limit for SSI-related Medically Needy. Mr. K is not eligible for Medicaid in July as an SSI-related person. Eligibility for the retroactive period, if requested, is examined separately.

   Mr. K is considered as an FMAP-related person for July in determining Medicaid eligibility for the family, because they meet the resource limit on July 29 by applying the FMAP-related policies.

   Mr. K then has the choice of being SSI-related beginning the month of August. If he chooses to be SSI-related, he is a responsible relative on the FMAP-related case and his resources are used to determine eligibility for the FMAP-related case.

2. Mr. B receives SSD and he has a savings account of $5,000. His child has a savings account of $1,500. Mr. B wants to be considered as an SSI-related person. His resources of $5,000 are considered against the resource limit for Medically Needy for the SSI-related case.

   His child is considered as an FMAP-related person. Mr. B is a responsible relative on the FMAP-related case. The household's resources are not considered in determining eligibility for the child on the FMAP-related case.

If a resource is jointly owned by FMAP-related clients and SSI-related clients, use the policies of the program for which each client is eligible. That is, treat SSI-related clients on the SSI-related case according to SSI resource policies. Treat the FMAP-related clients and responsible relatives on the FMAP-related case according to FMAP policies.

The B family has two cases:

- The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
- The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

The B family's resources are as follows:

Mr. B:	Car equipped for his disability
	$1,400 life insurance with cash value of $200
Mrs. B:	Car with $4,600 equity value
Bobbie:	$10 savings account
Barbie:	$15 savings account

Countable resources are computed as follows:

SSI-related household:

The car equipped for Mr. B's handicap is excluded.
Mr. B's life insurance is exempt, as its face value is less than $1,500.
The equity value of Mrs. B's car is countable.
Countable resources are $4,600.

FMAP-related household (to determine eligibility for Mrs. B):

Mr. B's car is exempt.
Mrs. B's car is exempt.
Mr. B's life insurance policy is exempt.

$	10	Bobbie's savings
+	15	Barbie's savings
$	25	Total resources for FMAP-related HH members

The B family's SSI-related household and FMAP-related household are both resource-eligible for Medically Needy.

INCOME POLICIES

Legal reference: 441 IAC 75.1(35)"b"; 75.1(35)"d"; and 75.1(35)"e"

Treatment of income in a Medically Needy case varies depending on whether the person is:

- FMAP-related or CMAP-related
- SSI-related
- In a medical institution

After calculating the eligible group's countable income, compare it to the Medically Needy income level (MNIL). The MNIL is calculated according to the federal formula, based on 133% of the FMAP schedule of basic needs as of July 16, 1996. The MNIL is based on family size, as follows:

Number of people	1	2	3	4	5	6	7	8	9	10	Each additional
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158	add $116

People whose net countable income is **equal to or below the MNIL** are eligible for Medically Needy without meeting a spenddown. People with a zero spenddown are approved for ongoing eligibility.

People whose net countable income is **above the MNIL** have a spenddown to meet and are conditionally eligible for Medically Needy. The spenddown amount is the difference between the net countable income and the MNIL.

"Spenddown" is the process by which a Medically Needy person's excess income is obligated for allowable medical expenses to reduce countable income to the applicable MNIL. When allowable medical expenses reduce income to the applicable MNIL, the conditionally eligible person is then eligible for Medicaid for the certification period. See APPLYING MEDICAL EXPENSES TO SPENDDOWN.

When you have determined eligibility and spenddown status, send form 470-2330, *Notice of Decision for Medically Needy*, to the client.

- If the client has ongoing eligibility, the notice must contain:
  - The client's name and address.
  - The name of the eligible persons.
  - Manual and rule references.
  - The effective date.
- When the client has a spenddown, the notice must contain:
  - The client's name and address.
  - The names of the conditionally eligible persons.
  - The names of any responsible relatives.
  - The beginning and ending dates of the certification period.
  - The amount of the spenddown.
  - The last date that claims can be submitted to meet spenddown for this certification period.
  - Manual and rule references.
- Send a copy of the applicable *Medically Needy Spenddown Computation Worksheet* with the notice. (See the following sections for the forms applicable to each coverage group.)

The following sections describe:

- Income and spenddown calculation for FMAP-related and CMAP-related cases.
- Income and spenddown calculation for SSI-related cases.
- Income and spenddown calculation for the retroactive period for all types of cases.
- Treatment of income when a person is in a medical institution, for all types of cases.

FMAP-Related and CMAP-Related Cases

Legal reference: 441 IAC 75.1(35)"b"; 75.1(35)"d"; 75.1(35)"e"

Follow FMAP income policies for FMAP-related or CMAP-related eligibles (but **do not** apply the income limit and the 58% work incentive deduction).

For FMAP-related or CMAP-related cases, count all unearned and earned income of all responsible relatives, eligible persons, and conditionally eligible persons living together to determine eligibility, unless the income is specifically exempted, disregarded, deducted for work expenses or diverted.

To determine countable income of the Medically Needy eligible group, do not consider:

- The income of any person receiving FMAP or SSI.
- The income of any person who is voluntarily excluded unless the voluntarily excluded person is the parent.
- The income of a responsible relative that has been diverted to an FMAP household.

Complete the income computations on form 470-3088, *FMAP-Related Medically Needy Spenddown Computation Worksheet*.

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the projected income unless actual income is available. Use the following guides in determining what income to use:

- Base initial and ongoing FMAP-related Medically Needy eligibility on projected income. If the projected future income is not valid for the month of application, month of decision, or any months in between, use actual income received in the month to determine eligibility for that month.
- For applications, recertifications, or reviews, project income using all nonexempt income. See 8-E, Projecting Income, for more information on FMAP-related policies.
- Accept the statement of the client as to whether the 30-day period is representative of future income. If the client states that the 30-day period is not a good indicator of future income, use either a longer period of time that is a good indicator of future income or verification of future income from the income source.
- The decision on whether to use a longer period of time or to request verification of future income from the income source should primarily be the client's. However, when the client is unsure of which would be the best indicator of future income, request verification from the income source. Also, if the client does not have pay stubs from either the 30-day period or from a longer time period, request verification from the income source.

- When a third or fifth check occurs during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly. See 8-E, Projecting Income.
- For people who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence. Project the monthly amount for the same period of time. See additional information on determining self-employment income in 8-E.

The following sections describe:

- General instructions for calculating an FMAP-related or CMAP-related spenddown.
- More specific instructions on income and spenddown for:
  - Households with a stepparent.
  - Households with a newborn child.
  - Households with an alien member.
  - Households with lump-sum income.
  - Household members who are sanctioned for failure to cooperate.

FMAP-Related or CMAP-Related Spenddown Calculation

Legal reference: 441 IAC 75.1(35)"d," 75.1(35)"e"

To calculate spenddown on an FMAP-related or CMAP-related case:

1. Apply all allowable deductions to each month's income.
2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)
3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered. Include all unborn children for FMAP-related or CMAP-related households if pregnancy has been verified in writing.

4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.

5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.

6. Assign a two-month certification period if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment until the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. People with a spenddown are "conditionally eligible recipients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mr. and Mrs. B and Baby B (FMAP-related group)	
Certification period:	January and February	
Net countable income:	$600 + $666 =	$ 1,266
MNIL	$566 + $566 =	– 1,132
Spenddown		$ 134

Because income exceeds the MNIL, the B family must incur $134 in medical expenses before they are eligible for Medicaid in January or February for the family. Note: Baby B is MAC-eligible and is a considered person for Medically Needy.

7. If the household's income **is equal to or less than** the MNIL in the two prospective months, the client has a zero spenddown. An FMAP-related or CMAP-related client with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. The client completes form 470-3118 or 470-3117(S), *Medicaid Review*, as the review form.

   If the FMAP-related or CMAP-related person's net countable income exceeds the MNIL in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

Ms. B applies for Medically Needy on October 15. She has two children eligible for MAC. Ms. B receives $300 child support for each child.

$	550.00	October ($600 - $50 exemption)
+	550.00	November ($600 - $50 exemption)
$	1,100.00	
–	1,132.00	MNIL ($566 × 2)
$	0.00	Spenddown

Her application is approved on November 1, effective October 1. Since Ms. B has zero spenddown, she has ongoing eligibility for FMAP-related Medically Needy.

On February 1, Ms. B reports that she began working on January 29 and will receive her first paycheck February 9. On February 12, Ms. B verifies that her income will be $280 per week and that she will receive three checks in February and five checks in March.

$	550.00	February ($600 - $50 exemption)
+	840.00	$280.00 × 3 checks
–	168.00	20% earned income deduction
$	1,222.00	Net countable income

$1,222 exceeds the MNIL of $566. On February 16 the worker sends a *Notice of Decision* assigning Ms. B a two-month certification period for March and April. (**Note:** To determine the March earned income and the April earned income, the worker projects four paychecks of $280 each, based on the verification from the employer.)

8. Determine eligibility for the retroactive period. See Income and Spenddown in the Retroactive Period.

Households With a Stepparent

Legal reference: 441 IAC 75.1(35)"a" and 75.14(249A)

In a stepparent household in which there are no common children and the stepparent has no children, do not include the stepparent when determining the Medically Needy household size, unless the stepparent is incapacitated or needed to care for the children in the home.

Use the FMAP standard of need to calculate how much to divert to the stepparent's needs. If income remains after diverting the FMAP standard of need to the stepparent, use the remaining income to calculate spenddown.

Include the stepparent as a financially responsible relative to allow the stepparent's medical bills to meet spenddown if any of the stepparent's income has been used to determine the spenddown amount.

The household consists of Mr. and Mrs. S and her two children from a previous marriage. Spenddown is computed as follows:

$ 3,000.00	Mr. S's gross earned income
- 600.00	20% earned income deduction
$ 2,400.00	
- 365.00	Diversion to meet needs of Mr. S, based on the FMAP standard of need
$ 2,035.00	
- 100.00	Deduction for child support for a dependent outside the household
$ 1,935.00	Amount considered towards spenddown

The $1,935 is compared to the MNIL for a three-member household. Mr. S is not included in the household size in determining the MNIL. However, he is coded as a responsible relative on the system, because he has income that is countable for the Medically Needy household.

Refer children to ***hawk-i***.

When the family chooses to voluntarily exclude the stepparent's income, the natural or adoptive parent is excluded from the eligible group. The income of the stepparent is not counted, and bills of the stepparent cannot be used to meet spenddown. Income of the natural or adoptive parent must be counted for the eligibility determination, and bills of the parent can be used to meet spenddown.

When there is a common child, or the stepparent has a child, the stepparent can be included in the Medically Needy household.

The household consists of Mrs. T and Mr. T, their common child, and Mrs. T's child. Mr. T, the stepparent, has gross income of $1600. His income exceeds the gross income test for FMAP. Mrs. T does not have income.

The children are determined to be eligible for MAC.

Mr. and Mrs. T also want medical assistance.

$ 1,600.00	Mr. T's gross income
- 320.00	20% earned income deduction
$ 1,280.00	Net countable income
$ 2,560.00	Countable income ($1280 x 2 months)
- 1,332.00	MNIL for a four -person household ($666 x 2 months)
$ 1,228.00	Spenddown

Households With a Newborn

When there is a newborn common child in a stepparent household, divert from the stepparent's income to meet the newborn's needs. The amount to divert is the difference between the standard of need with the ineligible newborn child included and the ineligible newborn excluded.

The household consists of Mr. and Mrs. K, Mrs. K's child, A, and their child, C. C is a newborn child of a Medicaid-eligible mother and continues to have a newborn status. Mr. K's gross earned monthly income is $2000. Mrs. K's gross earned monthly income is $1550. Their income is considered as follows for determining the spenddown:

$ 2,000.00	Mr. K's gross earned income
- 400.00	20% earned income deduction
$ 1,600.00	
- 354.00	Diverted to meet the needs of the newborn (difference between a two-person and a one-person standard of need: $719 - 365 = $354)
$ 1,246.00	
- 365.00	Diverted to meet the needs of the stepparent (standard of need for one person).
$ 881.00	Income considered towards the FMAP-related Medically Needy group
$ 1,550.00	Mrs. K's gross earned income
- 310.00	20% earned income deduction
$ 1,240.00	
+ 881.00	Income from Mr. K
$ 2,121.00	Net countable income
$ 4,242.00	Countable income ($2121 x 2 months)
- 1,132.00	MNIL ($566 x 2 months)
$ 3,110.00	Spenddown

If the newborn common child is not in a stepparent household, do not divert to meet the newborn's needs.

The household consists of Mrs. P and her two children (A and B), Mr. T, common child C, and newborn common child D. D is a newborn child of a Medicaid-eligible mother and continues to have newborn status.

The Medically Needy FMAP-related household consists of all household members except the newborn, child D. Mrs. P and Mr. T cannot divert any income to child D, as they are both part of the eligible group.

Households With an Alien Member

Legal reference: 441 IAC 75.1(35)"a" and 75.14(249A)

Include in the Medically Needy eligible group an alien who is eligible for Medicaid. See 8-L, *ALIENS*.

If the ineligible alien is an adult and meets all other eligibility criteria:

- Include the ineligible alien in the household size as a "considered" person.
- Count the income and resources of the ineligible alien.
- Use bills of the ineligible alien "considered" person to meet the spenddown for the eligible group.

If the ineligible alien is a child:

- Do not include the child in the eligible group.
- Exclude the income of the child.
- Do not use bills of the child to meet spenddown for the eligible group.

An ineligible alien may be eligible for Medicaid if an emergency medical condition exists. When the three days of emergency medical services occur during one month, the Medically Needy certification period is one month. When the three days of emergency medical services spans two months, the Medically Needy certification period is two months. See 8-L, Limited Eligibility for Certain Aliens.

Households With Lump-Sum Income

Legal reference 441 IAC 75.1(35)"d"(1)

Receipt of a lump sum does not make a person ineligible for the Medically Needy coverage group. Treat the receipt of a lump-sum payment according to FMAP policies.

Add lump-sum income and any prospective countable income for FMAP-related Medically Needy together. Prorate the total by the FMAP schedule of living costs based on household size. (See 8-E.)

If the client received the lump sum in a retroactive month and wants retroactive benefits, prorate the lump sum plus any other countable income received in that month and use it beginning in the month of receipt.

Remember:

- Use the prorated lump sum to determine countable income for the certification period.
- A break in assistance does not affect the prorated amount or the period of time the lump sum is counted as income for FMAP. If the client later applies for FMAP, remember to consider the period of ineligibility because of the lump sum. For Medically Needy, continue to use the prorated amount for all months as originally determined.

Use FMAP policies in 8-E, Conditions for Shortening the Period of Proration, to shorten the period of time the lump sum is counted as income.

Household composition: Mr. and Mrs. E and their three children (FMAP-related)

Certification period: January and February
Lump sum inheritance: $10,500 received January 5

Mr. E has net countable earned income of $650 for January and $800 for February.
Mrs. E has unearned income of $500 for January and $700 for February.

Total lump sum and January income: $11,650

Proration of lump sum and January income: $11,650 ÷ 1,092 = 10.66 months to consider the lump-sum income

			January and February		
Prorated lump sum	$1,092		$1,092		
Mr. E's income		+	800		
Mrs. E's income		+	700		
Total for certification period	$1,092	+	$2,592	=	$3,684

Note: The children are eligible for MAC in the month of January. The children are responsible relatives on the Medically Needy case for the month of January. The parents have been on Medically Needy before and there has not been a break in assistance.

Noncooperation

When the parent or specified relative who is conditionally eligible does not cooperate (e.g., with support recovery, Quality Control, or the Third-Party Liability Unit), that person is ineligible for Medicaid. However, the person remains a member of the household as a "considered" responsible relative for the purpose of establishing household size.

Use the ineligible person's income and allow the work expense deduction to determine the amount of spenddown.

Use the unpaid medical expenses of the parent or specified relative who has failed to cooperate to meet the spenddown.

SSI-Related Cases

Legal reference: 441 IAC 75.1(35)"a"; 75.1(35)"d"(2), (3)

When determining eligibility, consider the income of all responsible relatives and all conditionally eligible persons living together. Do not consider the income of:

- A responsible relative that has been diverted to a FIP household.
- A responsible relative that has been deemed to a person receiving SSI.
- Any person receiving FMAP or SSI. (**Note:** A 1619b person is not considered an SSI recipient for Medically Needy.)

Follow SSI policy to determine the amount of income to be deemed from the ineligible spouse, parent, spouse of a parent, or ineligible child.

Mr. and Mrs. Z are both disabled. Mr. Z receives Medicaid as a 1619b person. He works and receives social security disability. Mrs. Z has no income. Mrs. Z applies for Medicaid. The household size is two. The worker calculates the spenddown based on the couple's combined income, using SSI policies.

Complete the earned income computations on either:

- Form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*, or
- Form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet*.

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the best estimate, unless actual income is available. Follow SSI policy to determine the amount of income to consider. Use the following guides in determining what income to use:

- For applications or reviews, project income using all nonexempt income. See 8-E, Projecting Future Income, for more information on SSI-related policies.
- Convert weekly income to monthly income by multiplying by 4.3 and convert biweekly income to monthly income by multiplying by 2.15.
- If income fluctuates, use an average over a longer period of time if that would more accurately reflect the household's income. However, consider past circumstances only to the extent that they reasonably reflect what can be expected to occur in the future. Base projections of future circumstances on the best information available at the time of decision.
- When an income change has occurred or is anticipated, obtain a statement from the employer regarding future income.
- For persons who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence. Project the monthly amount for the same period of time. See additional information on determining self-employment income in 8-E.

If an SSI-related person receives a lump sum payment, treat it as described in 8-E, Lump-Sum Income. If the lump-sum is received on a one-time basis and is over $10 and is earned income, or is over $20 and is unearned income, consider it as income in the month of receipt.

The following sections describe:

- General instructions for calculating an SSI-related spenddown.
- More specific instructions on income and spenddown for households with an ineligible spouse and children.

SSI-Related Spenddown Calculation

Legal reference: 441 IAC 75.1(35)"d"; 75.1(35)"e"; 76.7(249A)

To calculate spenddown on an SSI-related case:

1. Apply all allowable deductions to each month's income.

Mr. E, 65, SSI-related, receives each month $800 in social security benefits, $125 in Veterans aid and attendance, and $100 IPERS. (Veteran's aid and attendance is not countable income for Medicaid eligibility determination.)

$	800.00	Social security
+	100.00	IPERS
$	900.00	Gross income
-	20.00	Disregard (SSI-related)
$	880.00	Net income (used to determine the spenddown for a one-member household)

2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)

3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered.

4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.

5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.

6. Assign a two-month certification period, if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment unless the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. Persons who have a spenddown are "conditionally eligible clients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mrs. B (SSI-related)				
Certification period:	January and February				
Net countable income:	$800	+	$866	=	$ 1,666
MNIL:	$483	+	$483	=	- 966
Spenddown:					$ 700

Because income exceeds the MNIL, Mrs. B must incur $700 in medical expenses before she is eligible for Medicaid in January or February.

7. If the household's net countable income is **equal to or less than** the MNIL in the two prospective months, the member has zero spenddown. An SSI-related member with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. (These members complete form 470-3118 or 470-3118(S), *Medicaid Review*, as the review form.

   If the SSI-related client's net countable income exceeds the MNIL plus insurance deductions in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

8. Determine eligibility for the retroactive period. See Income and Spenddown in the Retroactive Period.

1. Ms. A, age 45, applies for Medically Needy on August 8. Her monthly gross social security disability check is $800. Ms. A does not have Medicare.

$ 800.00	August social security
+ 800.00	September social security
$ 1,600.00	
- 40.00	General income exclusion ($20 × 2)
$ 1,560.00	
- 966.00	MNIL ($483 × 2)
$ 594.00	Spenddown
- 600.00	Health insurance premium ($300 × 2)
$ 0.00	Spenddown after insurance

On August 15, her application is approved effective August 1. Since Ms. A has a zero spenddown, Ms. A has ongoing eligibility for SSI-related Medically Needy.

On January 5, Ms. A reports to her worker that her social security disability increased to $846 and that she no longer has health insurance. The worker determines that the January social security disability increase ($846 - $20 general disregard = $826) exceeds the MNIL of $483. Ms. A is assigned a two-month certification period for February and March.

Ms. A continues to complete the *Medicaid Review* every two months to reapply.

2. Mr. B, age 75, applies for Medically Needy on August 2. His monthly gross social security income is $740. Mr. B is also QMB-eligible. Medicaid pays his Medicare Part B premium.

$ 720.00	August social security ($740 - $20 general exclusion)
+ 720.00	September social security ($740 - $20 general exclusion)
$ 1,440.00	
- 966.00	MNIL ($483 × 2 months)
$ 474.00	Spenddown
- 80.00	Dental insurance (40 × 2 months)
- 400.00	Nursing home insurance ($200 × 2 months)
0.00	Remaining spenddown

Mr. B has a zero spenddown and, therefore, has ongoing eligibility.

The Bendex report at the end of November indicates that Mr. B's social security increases to $762 effective January 1. Mr. B also reports that he will start receiving an annuity payment of $100 per month beginning January 5. The worker determines that Mr. B's income will exceed the MNIL for a one-person household in January.

$	762.00	January social security
+	100.00	Annuity income
-	20.00	General income exclusion
$	842.00	
-	483.00	MNIL
$	359.00	Spenddown
-	40.00	Dental insurance
-	200.00	Nursing home insurance
	119.00	Spenddown after deducting insurance

Mr. B is redetermined to be eligible for Medically Needy with a spenddown. The worker calculates the spenddown for the two-month certification period of January and February. The worker issues a timely notice of decision in December to Mr. B explaining that he is now certified for a two-month certification period, that his spenddown is $238, and that he will need to reapply for the month of March. (Mr. B continues to be QMB-eligible.)

3. Mrs. C, age 70, applies for Medically Needy August 18. Mrs. C receives $740 gross social security and is also QMB-eligible. Medicaid pays her Medicare Part B premium. Mrs. C also pays $240 monthly for a Medicare supplemental insurance policy.

$	720.00	August social security ($740 - $20 general income exclusion)
+	720.00	September social security ($740 - $20 general income exclusion)
$	1,440.00	
-	966.00	MNIL ($483 × 2 months)
$	474.00	Spenddown
-	480.00	Health insurance premium ($240 × 2 months)
$	0.00	Spenddown after health insurance premium

Mrs. C has ongoing eligibility for Medically Needy.

On October 1, Mrs. C reports that she no longer has a Medicare supplement. The worker redetermines Mrs. C's Medicaid eligibility.

$ 740.00	October social security
- 20.00	General income exclusion
$ 720.00	
- 483.00	MNIL
$ 237.00	Spenddown

Mrs. C no longer has ongoing eligibility. The worker calculates the spenddown for November and December. The worker notifies Mrs. C with a timely notice in October that she has been redetermined to be eligible for Medically Needy with a spenddown of $474 for the certification period of November and December. (Mrs. C continues to be eligible for QMB.)

4. Child A is under age 18 and disabled. His mother receives $899 social security disability per month. His father earns $1,071 per month. Child A's social security income is $450.

   Child A and Mrs. A will be on separate SSI-related Medically Needy cases.

   First, determine the amount of spenddown for Mrs. A. Follow instructions in 8-E for deeming from an ineligible spouse. Child A is treated as an ineligible child in this determination. Child A's income exceeds $337, so no income of the father can be allocated to child A. ($337 is the maximum amount to deem to an ineligible child.)

$ 899.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 879.00	Countable unearned income
$ 1,071.00	Mr. A's earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 879.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,382.00	Total countable income
$ 2,764.00	$1382.00 × 2 months
- 966.00	$ 483 × 2 months (MNIL for 2)
$ 1,798.00	Spenddown

Second, determine eligibility for child A. Follow instructions in 8-E for deeming from an ineligible parent to an eligible child. In this situation, Mrs. A is treated as an ineligible parent, as she is not receiving SSI. Use both parents' income to determine the amount of spenddown for child A.

$ 899.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 879.00	Countable earned income
$ 1,071.00	Mr. A's (father's) earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 879.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,382.00	Total countable income
- 1,011.00	Parental exclusion
$ 371.00	Deemed to child A
$ 450.00	Child A's income
- 20.00	General income exclusion
$ 430.00	Child A's countable income
+ 371.00	Income deemed from parents
$ 801.00	Total countable income
$ 1,602.00	$801.00 × 2 months
- 966.00	$483 × 2 months (MNIL for 1)
$ 636.00	Spenddown

Households With Ineligible Spouse or Children

Legal reference: 441 IAC 75.1(35)"d"(2), 75.1(35)"e"(1)

If the household includes the SSI-related person's spouse who is not aged, blind, or disabled, determine whether the ineligible spouse is a responsible relative.

If the case does not include children, deem income from the ineligible spouse to the SSI-related person. Do the deeming on form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*. If the ineligible spouse does not have income to deem, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

If the income of the ineligible spouse is deemed to the eligible spouse, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. Use the ineligible spouse's medical bills to meet spenddown.

If the household includes children, use form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet*. First, deem income from the ineligible spouse's income to meet the needs of each child. Calculate the needs of each child at $319 minus any income of the child. Then determine if there is income from the ineligible spouse to deem to the eligible spouse.

If there is income to deem, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. The ineligible spouse's medical bills can be used to meet the spenddown.

If the ineligible spouse does not have income to deem to the eligible spouse, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

Examine the case to determine if the ineligible spouse and children are eligible as an FMAP-related case. If the SSI-related person is a responsible relative on the FMAP-related case, apply FMAP policy to the person's income and resources to determine eligibility for the FMAP-related household members. See SSI-Related, FMAP-Related Composite Households.

1. Household composition:

   Mr. C, 70, has monthly unearned income of $740
   Mrs. C, 60, not blind or disabled; has monthly earned income of $816

   Mr. C's income exceeds SSI standards and he is requesting Medicaid eligibility through the Medically Needy program. The Medically Needy spenddown calculation is as follows:

   Step 1: Determine if Mrs. C will be a responsible relative (if she would have income deemed to Mr. C). Mrs. C's gross income of $816 exceeds $337. Proceed with the deeming process.

Step 2: Determine how much of Mrs. C's income to deem to Mr. C.

$ 816.00	Mrs. C's earned income (ineligible spouse)
- 65.00	Work exclusion
$ 751.00	
- 375.50	1/2 remainder
$ 375.50	Countable earned income available to Mr. C

Step 3: Determine Mr. C's spenddown.

$ 740.00	Mr. C's unearned income
- 20.00	General income exclusion
$ 720.00	Mr. C's countable income
+ 375.50	Mrs. C's income deemed to Mr. C
$ 1,095.50	Total monthly countable income
$ 2,191.00	$1,095.50 (monthly income) × 2 months
- 966.00	MNIL for 2 (483 × 2 months)
$ 1,225.00	Spenddown

Therefore, Mr. C is considered a conditionally eligible person and Mrs. C is considered as a responsible relative as she deemed income to Mr. C.

2. Mr. M has applied for Medicaid. He receives $740 social security disability benefits. Mrs. M receives unemployment insurance benefits (UIB) of $440. They have two children, Y and Z. Each child receives $185 social security benefits.

$ 740.00	Unearned income of Mr. M
- 20.00	General income exclusion
$ 720.00	Countable unearned income
$ 674.00	SSI benefit for one person
- 720.00	Mr. M's countable income
$ 0.00	

Mr. M's income does create ineligibility for SSI. Proceed to the deeming process for SSI-related Medically Needy:

$ 440.00	Mrs. M's unearned income
- 152.00	Allocation for ineligible child Y ($337 - 185 = $152)
- 152.00	Allocation for ineligible child Z ($337 - 185 = $152)
$ 136.00	Mrs. M's countable unearned income

$136 does not exceed $337. As the income is less than $337, there is no income available to deem to Mr. M.

Mr. M's countable income of $720 is compared to the MNIL for a household size of one to determine the spenddown amount. Mrs. M is not a responsible relative on Mr. M's case.

SSI-Related, FMAP-Related Composite Households

Legal reference: 441 IAC 75.1(35)"d"(1), (2)

An SSI-related client is a responsible relative or considered person on the FMAP case if the client is a:

- Parent of a child on the FMAP-related case.
- Sibling of a child on the FMAP-related case.
- Child of a parent on the FMAP-related case.

This is a composite case. Treat the person's income and resources according to SSI policy on the SSI-related case. Treat the person's income and resources according to FMAP policy on the FMAP-related case.

Use the same medical bills to meet spenddown on both cases when a person is conditionally eligible on one case and a responsible relative on the other case. Use only the portion of the medical bill that will not be paid by Medicaid to meet spenddown.

1. Household composition:

   Mr. B, 60, receives $846 per month in social security disability benefits
   Mrs. B, 55, receives $1,340 gross earned income each month
   Their children: Bobbie, 10, receives $212 social security
   Barbie, 9, receives $212 social security

   The B family requests Medicaid for all members. Mr. B chooses to be SSI-related, due to his verified disability. Mrs. B is an FMAP-related specified relative. Bobbie and Barbie are FMAP-related children. There are no child care costs.

This household has two cases:

- The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
- The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

The **SSI-related income calculation** for the B family is as follows:

To determine if Mrs. B will be a responsible relative for Mr. B's SSI-related case, determine if she would have income deemed to Mr. B following SSI policy.

$ 1,340.00	Mrs. B's gross earnings
- 125.00	Allocation for Bobbie's unmet needs ($337 - 212)
- 125.00	Allocation for Barbie's unmet needs ($337 - 212)
$ 1,090.00	

$1,090 exceeds the difference of the SSI benefit rate for an eligible couple and the SSI benefit rate for an individual ($337). Proceed to deeming calculation step. (If Mrs. B's income at this point were less than $337, deeming would not be applicable.)

$ 1,090.00	Mrs. B's remaining earned income
- 65.00	Work exclusion
$ 1,025.00	
- 512.50	1/2 the remainder
$ 512.50	Amount of Mrs. B's income deemed to Mr. B

$ 846.00	Mr. B's unearned income
- 20.00	General income exclusion
$ 826.00	Mr. B's countable unearned income
+ 512.50	Mrs. B's income deemed to Mr. B
$ 1,338.50	

$ 2,677.00	Income for the certification period ($1,338.50 × 2 months)
- 966.00	MNIL for the certification period ($483 × 2 months)
$ 1,711.00	Spenddown

The MNIL is for a two-person household. Mrs. B is a responsible relative on the SSI-related case, as she deemed income to Mr. B.

The **FMAP-related income calculation** for the household is:

Unearned income:

$ 846.00	Mr. B's social security disability
+ 212.00	Bobbie's social security
+ 212.00	Barbie's social security
$ 1,270.00	

Earned income:

$ 1,340.00	Mrs. B's gross earnings
- 268.00	20% earned income deduction
$ 1,072.00	Countable earned income

Total income:

$ 1,270.00	Total unearned income
+ 1,072.00	Countable earned income
$ 2,342.00	Total countable income

$ 4,684.00	Income for the certification period ($2,342 × 2 months)
- 1,332.00	MNIL for the certification period ($666 × 2 months)
$ 3,352.00	Spenddown

MNIL is for a four-person household. Mr. B is a responsible relative on the FMAP-related case. Spenddowns for the family in Example 1 are:

$1,711 for the SSI-related Medically Needy case.
$3,352 for the FMAP-related Medically Needy case.

Note: Bobbie and Barbie are eligible for MAC and are considered people on the FMAP-related case.

2. Mr. B from Example 1 has ongoing medical expenses of $1,000 per month.

   The worker advises the Bs to have two cases: SSI-related and FMAP-related. With an SSI-related case, Mr. B will have $289 of his medical expenses paid after he meets the spenddown. The FMAP-related case will not meet spenddown. Therefore, Mr. B would not want to be a conditionally eligible person on the FMAP-related case. (**Note:** Mr. B is a responsible relative on the FMAP-related Medically Needy case.)

3. Bobbie from Example 1 has a hospital bill of $15,000 that occurred before the certification period and remains unpaid. This bill has not been used before to meet spenddown. Mr. B has ongoing medical expenses of $1,250 per month.

   The worker advises Mr. B to be a conditionally eligible person on the FMAP-related case for four certification periods. They would not be able to use Bobbie's old medical bill to meet spenddown on the SSI-related case.

   As a conditionally eligible person on the FMAP-related Medically Needy case, Mr. B could have Medicaid pay all of the medical expenses that he incurs during the first four certification periods.

   During the fifth certification period, Mr. B would need to have an SSI-related case, as he would have more medical expenses paid.

4. Mrs. B from Example 1 requires minor surgery during the certification period. For this certification period, Mr. B has only $250 in medical expenses per month.

   Since Mr. B does not have enough medical expenses to meet spenddown on an SSI-related Medically Needy case, the worker advises Mr. B to be conditionally eligible on the FMAP-related case. More medical bills would be paid for the family.

   Because there are no unusual expenses expected for the B family in the next certification period, the worker advises the Bs to have both an SSI-related and an FMAP-related case.

5. Household composition:

   Mr. G, 65, receives $740 monthly social security
   Mrs. G, 56, receives $185 monthly social security
   George, 15, is in school and receives $185 social security

   The categorical relationship of each person is:

   Mr. G: SSI-related (aged)
   Mrs. G: FMAP-related specified relative
   George: FMAP-related child

   The certification period is for May and June.

   The household chooses to receive Medically Needy benefits for the SSI-related member and the FMAP-related group. This household has two cases.

SSI-related Medically Needy household:

To calculate spenddown for Mr. G, first determine if Mrs. G will be considered as a responsible relative and if any of Mrs. G's income will be deemed to Mr. G.

George's income:	$	185.00	
Mrs. G's income:	$	185.00	Social security
	-	152.00	George: Allocation for ineligible child ($337 - 185)
	$	33.00	

$33 is less than $337. Therefore, Mrs. G's income is not deemed to Mr. G, and she is not a responsible relative.

$ 740.00	Mr. G's social security income
- 20.00	General income exclusion
$ 720.00	
× 2	Months
$ 1,440.00	
- 966.00	MNIL for a one-person household ($483 × 2 months)
$ 474.00	Spenddown

Mr. G is conditionally eligible for SSI-related Medically Needy. Medical expenses for Mrs. G and George are not usable in meeting the spenddown for Mr. G's Medicaid eligibility. Mrs. G and George are not coded on the ABC system as responsible relatives for the SSI-related case.

FMAP-related Medically Needy household:

The FMAP-related Medically Needy household is Mr. G, Mrs. G, and George. The household has the option of excluding George. The Gs do not exclude George.

The spenddown for the three-member FMAP-related household is calculated as follows:

Mr. G	$	740.00	Responsible relative (parent)
Mrs. G	+	185.00	FMAP specified relative
George	+	185.00	FMAP-related child
	$	1,110.00	Monthly net income to be considered for spenddown

$ 2,220	Income for two ($1,110 × 2 months)
- 1,132	MNIL for a three-person household ($566 × 2 months)
$ 1,088	Spenddown

Mr. G has a choice of receiving Medicaid as SSI-related or FMAP-related. In this situation, it is to Mr. G's advantage to be SSI-related. Mr. G is conditionally Medicaid-eligible on the SSI-related case.

Because Mr. G is not receiving SSI, his income must be used to determine eligibility for his child and spouse on the FMAP-related case. Therefore, he is a responsible relative on the FMAP-related case. Mrs. G is conditionally Medicaid-eligible on the FMAP-related case. George is a considered person on the Medically Needy case, as he is MAC eligible.

Mr. G has a medical bill of $250 that occurred in January. (**Note:** The family was not certified for Medically Needy in January.) This bill remains unpaid as of May 1. This bill is applied to the spenddown for Mr. G and is also applied to the spenddown of the FMAP-related case.

Mr. G also has a $1,000 medical bill that occurred in May. $224 of this bill will be applied to meet his spenddown. The remaining amount of the medical bill is Medicaid-payable. Therefore, only $224 of the $1,000 medical bill may be applied to the spenddown of the FMAP-related case.

	SSI-related	**FMAP-related**
Spenddown	$ 474.00	$ 1,088.00
January bill	- 250.00	- 250.00
	$ 224.00	$ 823.00
$1,000 May bill	- 224.00	- 224.00
	0.00	$ 614.00
	Spenddown met	Spenddown not met

If Mrs. G has medical bills, she must meet the remaining spenddown amount on the FMAP-related case.

Composite Households With Lump-Sum Income

Legal reference: 441 IAC 75.1(35)"d"(1), (2)

A lump sum payment received by a person in an SSI-related or FMAP-related composite household is treated according to the person's categorical relationship.

Household composition:

SSI-related:	**FMAP-related:**
Mr. H, SSI-related (disabled)	Mrs. H, FMAP-related specified relative
Mrs. H, responsible relative	Holly, 10, FMAP-related child
	Henry, 18, FMAP-related child
	Mr. H, responsible relative

The application date is July 1 and the date of decision is July 30. On July 10, the household receives a retroactive social security disability lump sum:

Mr. H receives $4,000
Mrs. H receives $666
Holly receives $666
Henry receives $666

The lump sums received by Mr. and Mrs. H are counted in full ($4,666) as July's income for the SSI-related case.

For the FMAP-related case, the lump sums for Mr. H, Mrs. H, Holly, and Henry are totaled and added to any other income received in that month and then divided by the standard of living costs for four to determine the number of months to consider the lump sum.

Lump sum	$ 5,998.00
July net countable income	900.00
Total lump sum & July income	$ 6,898.00

Proration of lump sum & July income $6,898 ÷ 986 = 6.99 months to consider the lump sum income.

	July	and	August
Prorated lump sum and July income	$ 986.00		$ 986.00
August net countable income			900.00
Total for certification period	$ 986.00		$1,886.00 = 2,872

Note: Holly and Henry are eligible for MAC and are considered persons on the FMAP-related Medically Needy case for the month of July.

Pages 60 through 62 are reserved for future use.

Income and Spenddown in the Retroactive Period

Legal reference: 441 IAC 75.1(35)"e"(3), (4); 75.22; 75.1(35)"d"(5)

Assign a retroactive period of one, two, or three months depending on which month the retroactive period begins. (See Retroactive Eligibility for determining which months to include in the retroactive period.)

Consider all months of the retroactive period in which eligibility under another coverage group does not exist as a "unit." The "unit" for the Medically Needy retroactive period may be one, two, or three months depending on the first month in which Medicaid-covered services were received. Count all income for this unit, even if the household is ineligible in any month (for example, because of excess resources).

Determine the income for the retroactive period by adding the net countable income for each month of the Medically Needy retroactive period to arrive at a total. Do not count income from a month of the retroactive period when eligibility for that month is established under a coverage group other than Medically Needy.

Determine the MNIL for the retroactive certification period by adding the MNIL for each month of the Medically Needy retroactive period to arrive at a total.

Compare the net countable income to the MNIL for the retroactive period. (Use all months of the retroactive period, as previously determined, even if the client was ineligible for a part of it.)

1. The household files an application November 10. The household paid a medical bill in August and has an unpaid medical bill in October. The retroactive period is August, September, and October. The household is over resource limits for September.

   Net countable income:

August	$ 700.00	
September	1,000.00	
October	+ 859.00	
	$ 2,559.00	Total net countable income for the retroactive period

Income from all three months is totaled and considered in determining spenddown. As September is an ineligible month, retroactive eligibility is coded as first and third prior months only. When the Eligibility Status Turnaround Document is received, all individuals' fund codes for the month of September are "9," not eligible.

2. The S family files an application November 15 and requests retroactive benefits. They indicate that they have an unpaid bill for Medicaid-covered services received in October. They did not receive any Medicaid-covered services in August or September.

   The retroactive period consists of October. Income from October is used to determine the spenddown for the retroactive period.

3. Mr. and Mrs. T apply for Medicaid April 2. Mrs. T was hospitalized in the month of February and the bills remain unpaid. They did not receive any Medicaid-covered services in January or March.

   The retroactive period includes the months of February and March. The worker uses income from February and March to determine the spenddown for the retroactive period.

4. Mr. and Mrs. G apply for Medicaid April 15. They paid medical bills in January and have unpaid bills in March. These bills were for Medicaid-covered services. They did not receive any Medicaid-covered services (paid or unpaid) in February.

   The retroactive period includes the months of January, February, and March. The worker uses income from all three months to determine the spenddown amount.

Income of an Institutionalized Person

Legal reference: 441 IAC 75.1(35)"d"(2)

Persons in medical institutions who have income exceeding the 300% Medicaid cap or resources exceeding the SSI resource limit may be conditionally eligible for Medically Needy **if all other eligibility factors are met**. **No payment is made for nursing facility care by Medicaid under the Medically Needy coverage group. Note:** The cost of the nursing facility care may be used to meet spenddown.

To determine Medically Needy eligibility for the community spouse of an institutionalized eligible spouse, use the community spouse's income plus any income diverted by the institutionalized spouse to the community spouse.

See 8-I, Income and Resources of Married Persons, for the policies on counting income and resources for spouses when one spouse enters a medical institution.

- When the institutionalized spouse is expected to stay in a medical institution less than 30 consecutive days, consider the resources and income of both spouses together in determining Medicaid eligibility.
- When the institutionalized spouse (who entered the institution on or after September 30, 1989) is expected to stay more than 30 consecutive days or has stayed 30 days, use only the institutionalized spouse's income to determine eligibility, both in the initial month and in the succeeding months.

  Complete an attribution of resources for the month that one spouse enters an institution expecting to stay 30 consecutive days when there is a community spouse.

1. Mrs. W, age 66, enters a nursing facility on June 16. Her monthly gross income is $1,164 social security and $870 IPERS. Her countable income of $2,034 exceeds the Medicaid cap for the 300% group and over resources for the 300% group. To determine Medically Needy countable income, deduct the $20 general income exclusion.

   Certification period: June - July income

$ 2,034.00	Gross unearned income
- 20.00	General income exclusion
$ 2,014.00	

$ 2,014.00	
+ 2,014.00	
$ 4,028.00	Net countable income for the certification period
- 966.00	MNIL for the certification period ($483 × 2 months)
$ 3,062.00	Spenddown

   Even if spenddown is met, no Medicaid payment will be made to the facility. Mrs. W is responsible for payments to the facility.

2. Mr. Z resides in a nursing facility. His monthly income is $737.00 social security and $564 IPERS. He is eligible for the 300% group ($737.00 + 564.00 = $1,301.00). Mrs. Z, the community spouse, has $587.00 social security and $200 IPERS.

Mrs. Z: Determination of unmet maintenance needs.

$ 2,739.00	Monthly minimum maintenance needs allowance
- 787.00	Mrs. Z's monthly gross income
$ 1,952.00	Unmet maintenance needs

Mr. Z:

$ 1,301.00	Total gross income
- 50.00	Personal needs
- 96.40	Medicare premium
$ 1,154.60	Amount that may be diverted to Mrs. Z.

Mrs. Z's Medically Needy determination:

$ 587.00	Social security income
+ 200.00	IPERS income
+ 1,154.60	Mr. Z's diversion for Mrs. Z's maintenance needs
$ 1,941.60	Total countable income
- 20.00	General income exclusion
$ 1,921.60	Net countable income
× 2	Months
$ 3,843.20	Two months of net countable income
- 966.00	MNIL for one for two months ($483 × 2)
$ 2,877.20	Spenddown

APPLYING MEDICAL EXPENSES TO SPENDDOWN

Legal reference: 441 IAC 75.22; 75.1(35)"e"(5); 75.1(35)"f"; 75.1(35)"g"

"Spenddown" is the process in which a Medically Needy person's excess income is obligated for allowable medical expenses in order to reduce countable income to the household's MNIL. When incurred medical expenses have reduced income to the applicable MNIL, the conditionally eligible person becomes eligible for Medicaid for the certification period.

Health insurance premiums and Medicare premiums are allowable medical expenses to meet spenddown. Deduct these premiums from the client's spenddown on the *Medically Needy Spenddown Computation Worksheet* to determine the **final** spenddown amount before entry of the spenddown amount on the ABC system.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy subsystem. The Medically Needy subsystem builds files for recipients with spenddown amounts and tracks the verified expenses applied to meet the spenddown obligation.

Providers submit claims to the Iowa Medicaid Enterprise (IME) for Medicaid-covered services incurred during the certification period.

The client or the provider submits information on non-Medicaid-payable expenses to you on a claim form. Attach the claim to *Medically Needy Transmittal*, form 470-3630, and submit both forms to the IME Medically Needy Unit by one of the following methods:

- Fax it to (515) 725-1350, or
- Send it to the IME Medically Needy Unit, Hoover Building, Des Moines.

Data from these claims is entered into the Medically Needy subsystem for processing. The Medically Needy subsystem prioritizes and accepts or rejects medical expenses, and automatically calculates whether spenddown has been met. The subsystem generates a computer-issued *Notice of Spenddown Status*, form 470-1967:

- Biweekly, when the IME Medically Needy Unit has input a claim.
- Biweekly, when changes in circumstances affect the spenddown calculation.
- On the day when a conditionally eligible recipient has met spenddown.

When the spenddown obligation is met, the Medically Needy subsystem notifies IME that the client is eligible for Medicaid and that certain bills are not payable because they were used to meet the spenddown obligation. The subsystem issues an *Eligibility Status Turnaround Document* (ESTD), form 470-1941, to document the case's status for each month of the certification period.

See 14-I(1) for information on ABC system entries for Medically Needy and 14-I for more information on the Medically Needy subsystem. See the following sections for more information on:

- Deducting health insurance premiums
- Deducting Medicare premiums
- Submitting Medical expenses for spenddown
- When medical expenses may be used to meet spenddown
- Allowable expenses for spenddown
- Determining the client's obligation
- Order of deducting expenses

Deducting Health Insurance Premiums

Legal reference: 441 IAC 75.1(35)"f," 75.1(35)"g"(2)

Verify health insurance premiums by bills from the insurance company, pay stubs, or other documentary evidence. MEPD premiums for the responsible relative are an allowable deduction from the spenddown amount. Prorate the premiums over the period they are intended to cover. Use the applicable *Medically Needy Spenddown Computation Worksheet* to deduct these amounts from the spenddown before entering it on the system.

Note: Premiums for insurance policies that pay a flat rate to the policyholder may be deducted from spenddown if:

- The policy was purchased to pay for medical care and with regard to anticipated charges, and
- The benefit is payable only if the policy holder actually receives the type of medical care for which the policy was purchased, and
- The benefit is intended to be used to pay for medical care for which the policy was purchased, and
- The benefit is not being counted as income for determining eligibility.

Note: Most discount drug plans are not health insurance contracts and thus should not be considered a health insurance premium. Obtain a copy of the plan if you are in doubt.

Do not allow the deduction for a premium that is paid by the Health Insurance Premium Payment (HIPP) program. Allow premiums paid by the AIDS/HIV Health Insurance Premium Payment program. See Medical Expenses Paid by a State Public Program.

When a client's countable income is below the MNIL and the health insurance premium is not used to meet the spenddown, the person may be eligible for the HIPP program. See 8-M, Who Is Eligible for HIPP. If the client is covered or could be covered by an employer's group health insurance plan, send a copy of the *Employer's Statement of Earnings*, form 470-2844, to the HIPP unit.

Deducting Medicare Premiums

Legal reference: 441 IAC 75.1(35)"g"(2), 75.52(5)

Medicare premiums are an allowable medical expense. However, do not allow deduction for the Medicare premium if it is paid by Medicaid.

People in the qualified Medicare beneficiary (QMB) coverage group cannot use Medicare premiums, deductibles or coinsurance to meet spenddown, because Medicaid pays these costs. Similarly, people in the specified low-income Medicare beneficiary (SLMB) and expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups cannot use the Medicare Part B premium to meet spenddown.

Iowa "buys in" Medicare premiums for all Medicaid members. The buy-in automatically occurs for people whose social security claim number is correctly coded and who receive Medicare Part B. The buy-in tape is sent two days before the ABC month end. If buy-in is in effect for a Medically Needy member, buy-in will continue if the client has met spenddown before the buy-in tape is sent.

For clients who are not QMB-, SLMB- or E-SLMB-eligible, determine if Medicare Part B buy-in is in effect. Do not allow the Medicare premium as a medical deduction for the current certification period if the buy-in is in effect or if there is time to enter the Medically Needy case on the ABC system before the buy-in tape is sent.

If the buy-in tape will not be updated until **after** the two-month certification period is entered onto the system **or** the client meets spenddown, allow the premium deduction for the entire two-month certification period.

If the buy-in tape will not be updated until after ongoing eligibility is entered onto the system, allow the premium deduction until buy-in occurs. On the applicable *Medically Needy Spenddown Computation Worksheet*, deduct the Medicare premium from the client's spenddown before entering it on the system.

Tell the client to notify you when the buy-in occurs. (You can also determine when buy-in occurs from the SSBI screen, from the Bendex report, by the change of the Medicare premium coding on the TD03 screen in ABC, or by the tickler.) When the buy-in occurs, recalculate the client's spenddown.

When the client meets spenddown at the end of the certification period or after the certification period, request a manual buy-in. To request a manual buy-in, notify the staff in the IME Policy Unit in writing by e-mail to: MedicaidMME. Provide the following information on the people whose Medicaid buy-in needs to be processed:

- Member's name.
- SID number.
- Social security claim number.
- Months of eligibility for buy-in.

1. Ms. Z applies for Medically Needy on December 11 for the first time. She does not want Medicaid in December. Her social security disability income is projected as follows:

January	**February**
$700.00	$700.00

Her Medicare premium is $96.40 for each month. Her Medicare supplement is $120.00. (She is over resources for QMB.) In processing the application on January 3, the IM worker determines that since Ms. Z is not already "bought in," the Medicare premium is allowable as a deduction. The calculation is as follows:

January		**February**		**Total Period**	
$ 700.00	+	$ 700.00	=	$ 1,400.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 680.00		$ 680.00		$ 1,360.00	Net income
- 483.00		- 483.00		- 966.00	MNIL
$ 197.00		$ 197.00		$ 394.00	Spenddown
- 96.40		- 96.40		- 192.80	Medicare premium
- 120.00		- 120.00		- 240.00	Medicare supplement
$ 00.00		$ 00.00		$ 00.00	

Since there is no spenddown in the initial two months, Ms. Z has ongoing eligibility.

When buy-in is reported, the IM worker recalculates the spenddown for the certification period. This causes the ongoing eligibility to be redetermined to a two-month certification period, since the Medicare premium is not allowed as a deduction after buy-in has occurred.

2. Mr. Y has been QMB-eligible. He applies for Medically Needy on December 11. He has social security disability income of $800 and Medicare premium of $96.40.

The IM worker is processing this application on January 3. The IM worker does not allow the Medicare premium as a deduction, since Mr. Y is in the buy-in process. (He is QMB-eligible.) The calculation for spenddown is as follows:

January		**February**		**Total Period**	
$ 800.00	+	$ 800.00	=	$ 1,600.00	Gross income
- 20.00	+	- 20.00	=	- 40.00	Disregard
$ 780.00	+	$ 780.00		$ 1,560.00	Net income
$ 483.00	+	$ 483.00	=	- 966.00	MNIL
				$ 594.00	Spenddown

3. Mr. Z has $950 gross social security and is over resources for SLMB. Mr. Z met his spenddown for the April-May certification and buy-in for his Medicare premium occurred in May. At the end of May, Mr. Z reapplies for Medically Needy for June-July certification. Since buy-in is already in effect and the application is being processed on June 3, no deduction is allowed for the Medicare premium.

June		**July**		**Total Period**	
$ 950.00	+	$ 950.00	=	$ 1900.00	Gross income
- 20.00	+	- 20.00	=	- 40.00	Disregard
$ 930.00	+	$ 930.00	=	$ 1860.00	Net income
$ 483.00	+	$ 483.00	=	- 966.00	MNIL
				$ 894.00	Spenddown

Mr. Z is assigned a two-month certification period. If spenddown is never met or is met after the buy-in tape is produced in January, buy-out will occur. On the next recertification, if buy-in is not in effect, allow the Medicare premiums (except for Part D) as a deduction. Mr. Z's Part D premium is paid by Extra Help for Medicare Part D.

4. Ms. A applies for Medically Needy and QMB on April 15. Her social security income is $680 and she pays the Medicare Part B premium. The IM worker processes the application on May 5. Ms. A is QMB eligible effective June 1. The IM worker allows the Medicare Part B premium as a deduction for the April - May certification period. The calculation for spenddown is as follows:

April		**May**		**Total Period**	
$ 680.00	+	$ 680.00	=	$ 1,360.00	Gross income
- 20.00	+	- 20.00	=	- 40.00	Disregard
$ 660.00	+	$ 660.00	=	$ 1,320.00	Net income
- 483.00	+	- 483.00	=	- 966.00	MNIL
$ 177.00	+	$ 177.00	=	$ 354.00	Spenddown
- 96.40	+	- 96.40	=	- 192.80	Medicare premium
$ 80.60	+	$ 80.60	=	$ 161.20	Final spenddown

Ms. A sends an application to the IM worker on June 2. The IM worker processes the application for the June - July certification period. Mrs. A is now QMB eligible. The Medicare Part B premium is not allowed as a deduction, as Medicaid is paying for it. Ms. A's spenddown for the June - July certification period is $354.

5. Mr. M applies for Medically Needy and QMB November 2. On November 20, Mr. M is approved for QMB effective December and for a November-December certification for Medically Needy. The Medicare premium is allowed for a deduction for November but is not allowed for December, because the client is eligible for QMB for December.

Submitting Medical Expenses

Legal reference: 441 IAC 75.1(35)"f"; 75.1(35)"g"(2)

Send the client a *Notice of Decision for Medically Needy* as soon as the certification period is on the ABC system. Attach form 470-3392, *Medicaid State ID Numbers*, to the *Notice of Decision*. Tell clients to inform their providers that they are on Medically Needy and that the provider should:

- Send claims for Medicaid-covered services occurring in the certification period to Iowa Medicaid Enterprise (IME).
- Send all other claims to the IM worker.

Conditionally eligible clients inform their providers that they have a spenddown to meet by showing the provider their *Notice of Decision for Medically Needy* when they receive services. If services are received in the certification period before the client gets the notice of decision, the client should inform the provider of the spenddown obligation.

The provider needs either the state ID number or the social security number for the person receiving the services in order to check the Eligibility Verification System (ELVS) for billing information. ELVS notifies the provider if the client is conditionally eligible and the remaining amount of spenddown.

When the conditionally eligible person or the responsible relative receives Medicaid-covered services during the certification period, the provider completes a paper claim, electronic claim, or point-of-sale claim, and sends it to the IME.

When the state ID number is on the SSNI system for the 37-E aid type with a "P" or "S" fund code for the month of service, the IME enters the claim information into the Medically Needy subsystem. The IME notifies the provider that the claim has been denied for payment and that the claim has been submitted for spenddown consideration.

If the client asks a provider to submit a claim to be used to meet spenddown before the certification period is on both the ABC system and the Medically Needy subsystem, the claim will be denied and will not be submitted for spenddown consideration.

Mr. and Mrs. A file an application for Medically Needy. The worker determines that they have a spenddown of $230 for a May-June certification period. Mrs. A calls and states that Mr. A has an unpaid medical bill of $50 at the Wall Clinic that was incurred four months ago. She also states that she has a medical bill of $80 at Pharmacy C for May 2.

The worker advises Mrs. A to show Wall Clinic and Pharmacy C the *Notice of Decision for Medically Needy*. Wall Clinic sends the $50 claim to the worker. Pharmacy C sends an $80 claim to the IME for spenddown consideration.

The worker also advises them to show the *Notice of Decision for Medically Needy* to providers during the certification period until they meet spenddown and get Medicaid cards.

Expenses Submitted Through IM Worker

Legal reference: 441 IAC 75.1(35)"f"; 75.1(35)"g"

When the conditionally eligible person or responsible relative has received services before the certification period or receives non-Medicaid-covered services during the certification period, the provider submits a paper claim form to the IM worker.

Note: If a provider questions submitting a paper claim instead of filing electronically, refer the provider to the ***MEDICAID ALL PROVIDERS MANUAL*, CHAPTER II. MEMBER ELIGIBILITY:** Medically Needy Conditional Eligibility.

Allow applicants 12 months after the end of the certification period to submit medical expenses to be used to meet spenddown. Allow 12 months from the date of the notice of decision when the certification period or the retroactive certification period has ended before the issuance of the notice of decision.

Claims that are received after the 12-month period can be used for later certification periods **only** if spenddown was met for the original certification period and the bill is not Medicaid-payable. **Exception:** Bills incurred in the retroactive period can be applied to the certification period immediately following the retroactive period.

When you receive claims, determine:

- Whether the claim is for a period of time that can be allowed for spenddown. (See When Incurred Medical Expenses May Be Used.)

- Whether the expenses are of a type that is allowable for spenddown. (See Allowable Medical Expenses for Spenddown.)
- Whether the client still remains obligated for the expenses. (See Determining the Client's Obligation.)

When the expenses meet these tests, submit the completed claim forms to the IME Medically Needy Unit **within five days of receipt**. Attach the *Medically Needy Transmittal* to the claim form. (If the provider does not send a claim for an old bill, attach the provider's statement to the *Medically Needy Transmittal*.)

Medical transportation costs incurred when the client was not certified for Medically Needy are an allowable deduction for spenddown if the transportation expense remains unpaid. Clients submit evidence of transportation medical expenses on form 470-0386 or 470-0386(S), *Medical Transportation Claim*.

When the client submits transportation expenses, determine whether the expenses remain unpaid on the first day of the certification period and whether a third-party payment is anticipated. If the expenses are allowable, transfer the information from 470-3630 onto the *Medically Needy Transmittal*.

When the client verifies residential care personal care services, enter the amount on the *Medically Needy Transmittal* and send it to the IME Medically Needy Unit.

If an alien who is only eligible for emergency services does not have a bill, a statement, or a claim, verify the diagnosis code. Mail form 470-4299, *Verification of Emergency Health Care Services*, to the provider for completion.

The Medically Needy subsystem generates the *Bill Status Turnaround Document* (BSTD), 470-1942, to track the application of the expenses to the spenddown. When the bill is large enough to be applied to more than one certification period, use the BSTD to resubmit it for subsequent periods.

Once spenddown is met, the Medically Needy subsystem will accept changes to:

- Decrease the amount of spenddown. (Use the ESTD.)
- Apply an old bill or noncovered Medicaid payable claim that occurred before the spenddown date. (Submit the claim with the *Transmittal*.) When this type of claim is received after spenddown has been met, the Medicaid covered claim will be backed out of the Medically Needy subsystem and the provider will be paid.

When Incurred Medical Expenses May Be Used

Legal reference: 441 IAC 75.1(35)"g"

Use paid or unpaid medical services that occurred in the certification period to meet the spenddown obligation for that period.

> The S family has a spenddown of $300 for the certification period of June and July. During June, they pay or incur $200 in medical expenses. In July, they pay or incur $125 in medical expenses. They are eligible for Medicaid as Medically Needy for June and July. The bills used to meet the $300 spenddown will not be paid by Medicaid.

Paid and unpaid expenses incurred in the retroactive period may be used to meet spend-down in the certification period that immediately follows the retroactive period if they were not used for spenddown in the retroactive period.

Use incurred medical expenses to meet spenddown only if they were not already used in full to meet spenddown in a previous certification period and were not Medicaid-payable. (**Note:** For these expenses to be allowed in the subsequent certification period, the spenddown in the previous certification period must have been met.)

Medical expenses incurred in a certification period where spenddown is not met cannot be used to meet spenddown in any subsequent certification period. If the spenddown was not met in a preceding certification period (other than the retroactive period), do not carry unpaid medical expenses that were incurred in that period forward to the current certification period.

See the following sections for more details on applying these expenses:

- Expenses from months not certified as Medically Needy
- Expenses from the retroactive period
- Expenses from a prior certification period

Expenses From Months Not Certified for Medically Needy

Legal reference: 441 IAC 75.1(35)"g"

Apply old unpaid bills for services received when the client was not certified for Medically Needy (conditionally eligible or eligible) to any certification period, regardless of whether or not spenddown was met in a certification period.

The unpaid bill must remain unpaid on the first day of the month of the certification period. Only the portion of the bill that was not used to meet a spenddown may be applied to a subsequent certification period. See Determining the Client's Obligation: Old Bills With Remaining Balances.

Ms. Z is conditionally eligible for the October-November certification period with a $200 spenddown. Ms. Z has a dental bill for $335 that she incurred on May 15. She was not certified for Medically Needy in the month of May.

The dentist submits a claim or bill indicating that Ms. Z still owes the $335. The dental expense is applied to the $200 spenddown for the October-November certification period. The dental bill has a remaining value of $135 that may be applied to the next certification period, if the expense remains unpaid.

Expenses From the Retroactive Period

Legal reference: 441 IAC 75.1(35)"g"

Use the following guidelines to apply paid or unpaid medical expenses incurred in the retroactive period to meet spenddown for the certification period that immediately follows the retroactive period:

- It does not matter if spenddown was met in the retroactive period.
- Use non-Medicaid-covered expenses that were incurred in the retroactive period to meet spenddown for the certification period that immediately follows it, if they were not used to meet spenddown in retroactive period. This applies whether the expenses are paid or unpaid.
- Use paid bills incurred in the retroactive period to meet spenddown in the certification period that immediately follows the retroactive period, if the expense has not been used to meet spenddown in the retroactive period. Do not use these paid expenses from the retroactive period to meet the spenddown for any subsequent certification period.

- If the bill incurred in the retroactive period is unpaid and is for a service that will be paid by Medicaid, do not use the bill to meet spenddown in the following certification period.

The certification period that "immediately follows" the retroactive period means that there has been no lapse in time between the retroactive certification period and the next certification period.

Note: If the retroactive period is not entered on the Medically Needy subsystem, the subsystem will not allow the paid medical bill from the retroactive period to be applied to the following certification period.

The M family files an application April 2 and does not request retroactive benefits. The worker contacts the family and asks if they have any unpaid medical bills in the retroactive months. Mrs. M states that they did not.

The worker then asks if they had paid any medical bills that the family incurred during the retroactive period. Mrs. M remembers that in February she took the children to the dentist for check-ups and paid the dental bill of $65. There were no other medical expenses in the retroactive period.

The worker determines the household has a spenddown of $500 for the retroactive period (February and March). The worker enters a two-month retroactive certification period on the Automated Benefit Calculation (ABC) system.

The family does not have any unpaid medical bills for services received before the retroactive period. The worker determines that the family would not meet the spenddown of $500 for the retroactive period with the $65 dental bill.

Therefore, the February dental bill of $65 is applied to the spenddown for the April-May certification period. The Ms have a spenddown of $500 for the April-May certification period.

Expenses From a Prior Certification Period

Legal reference: 441 IAC 75.1(35)"g"

When the spenddown has been met in the previous certification period, move the remaining value of unpaid non-Medicaid covered expenses from that certification period to the following certification period. (This does not apply to unpaid bills in the retroactive certification period being moved to the certification period that immediately follows the retroactive period.)

Medical expenses that occurred in a prior certification period that did not meet spenddown may **not** be used in a following certification period.

1. The M family has a $500 spenddown for the June-July certification period.

   Junior M incurs a medical expense of $800 on June 5 with a non-Medicaid provider. ($500 is applied to the spenddown and the remaining value of $300 may be applied to the next certification period if still obligated.) The M family meets the spenddown for the June-July certification period.

   The M family applies for the August-September certification period. They are approved with a spenddown of $500. Mrs. M still owes the non-Medicaid provider for her son's April bill. The $300 remaining value of the $800 medical expense that was not used before is applied to the spenddown amount.

   The M family does not incur any medical bills in the August-September certification period. Spenddown is not met for the August-September certification period. (**Note:** Spenddown was not met for this certification period, therefore, the $300 cannot be moved to the next certification period.)

2. Same situation as Example 1, except the M family does not apply for the August-September certification period. They wait and apply after Mrs. M is hospitalized in October. They are approved with a spenddown of $400 for the October-November certification period.

   The worker asks Mrs. M if they still owe the non-Medicaid provider the $300 from the $800 bill that was incurred in June. (Because the M family met spenddown for the June-July and this amount is still obligated it may be applied to the spenddown for the next certification period after the June-July certification period.)

   Mrs. M states that they still owe $200. This is verified with a call to the provider and the BSTD is submitted to indicate the payments of $400 on July 20 and $200 on September 10. The $200 is applied to spenddown and Mrs. M's hospital bill is used to meet the remaining spenddown amount.

Allowable Medical Expenses for Spenddown

Legal reference: 441 IAC 75.1(35)"g"

Apply actual expenses for necessary medical and remedial services and approved transportation expenses incurred by a recipient or conditionally eligible person or responsible relative to the spenddown amount for the certification period. This includes some over-the-counter drugs. See the Medicaid provider's manual for the covered services. Incurred medical expenses are:

- Medical bills paid during the certification period or retroactive certification period by:
  - A recipient or a conditionally eligible person.
  - A responsible relative.
  - A public program of a state or political subdivision (other than Medicaid).
- Unpaid medical expenses for which the recipient or conditionally eligible person or responsible relative remains obligated to pay. See When Incurred Medical Expenses May Be Used and Determining the Client's Obligation.

Bills for a person who is not a responsible relative or a conditionally eligible person cannot be used to meet spenddown. Bills of any person voluntarily excluded from the household cannot be used to meet spenddown.

The family consists of Ms. H, who receives child support, and her two children, ages 15 and 14. The 14-year-old is hospitalized. The 15-year-old, who receives $500 unearned income, is healthy.

When the 15-year-old is included in the Medically Needy household, there is a high spenddown caused by the 15-year-old's income. When the 15-year-old is excluded from the FMAP-related household, there is a much lower spenddown for the Medically Needy household. The family chooses to exclude the 15-year-old.

Only the incurred expenses of the Medically Needy household are used to reduce spenddown. Incurred expenses of the 15-year-old excluded child are not allowable in meeting spenddown.

If a person is conditionally eligible on one case and also a responsible relative or considered person on another case, use the same bills to meet both spenddowns. Do not include any portion of a bill paid by Medicaid. See SSI-Related, FMAP-Related Composite Households for examples.

If the noncustodial parent is legally responsible for medical expenses and does not pay, use these expenses for spenddown when the medical expenses revert to the conditionally eligible or responsible relative to pay.

When medical expenses are used to reduce the period of time a lump sum is considered, also use these same medical expenses to meet the client's spenddown.

The following sections give more detail in these areas:

- Noncovered Medicaid services
- Prepaid medical coverage
- Medical expenses of stepparents
- Medical expenses paid by a state public program
- Personal care services in a residential care facility
- Acupuncture services

Noncovered Medicaid Services

Legal reference: 441 IAC 75.22; 75.1(35)"g"

Bills for a service that is not "necessary," as defined by Medicare and Medicaid, cannot be used for spenddown.

Medical expenses that are ordinarily covered by Medicaid but are not payable for the Medically Needy client may be used for spenddown. This includes services that are not payable because:

- The provider is not enrolled in Medicaid.
- The expense is for a responsible relative who is not in the Medically Needy eligible group.
- Services were received before the start of the certification period.
- The service is a nonemergency service provided to aliens who are eligible only for payment of emergency medical expenses.

- The Medically Needy program does not pay for the service, although it is available under other Medicaid coverage groups. These services include:
  - Payment for care in a nursing facility or NF/MI.
  - Payment for care in a Medicare-certified skilled nursing facility.
  - Payment for care in an intermediate care facility for the mentally retarded.
  - Payment for care in an institution for mental disease.
  - Payment for rehabilitative treatment services. These are specified services in the family preservation, family-centered services, family foster care treatment, and group care programs.

Prepaid Medical Coverage

Legal reference: 441 IAC 75.1(35)"g"

With a prepaid medical package, such as orthodontia or prenatal care, allow the cost of medical services that:

- Were received during the certification period, or
- Remain unpaid as of the first day of the certification period.

Exception: For orthodontia for children that would be billed under Care for Kids (EPSDT) after spenddown is met, use the prepaid amount to meet spenddown. This is allowable because EPSDT allows Medicaid prepayment at the time of banding to cover active treatment and the retainer for a 30-month period. The client must obtain prior approval for Medicaid to pay any remaining amount. The client should pursue the prior approval immediately (before the spenddown is met).

1. The orthodontist requires a prepayment for braces of $2,000. The orthodontist received prior approval for the braces from the IME. The prepayment is due May 1. Mrs. X, age 28, pays the $2,000 on May 1. Mrs. X receives $200 in dental services for the month of May and $150 for the month of June.

   The worker allows only $350 to meet the spenddown for the May-June certification period. The remaining $1,650 that was paid is not allowed as a deduction in any certification period, as it does not represent an obligation for medical services received. The remaining medical services have been prepaid.

2. Mrs. Z asks the orthodontist if Medicaid would pay for the treatment. He states that for Medicaid to pay, prior approval needs to be requested and granted. Mrs. Z explains that they have a $500 spenddown to meet before they would be eligible.

   The orthodontist submits the request for prior approval January 5. After the dentist receives prior approval, treatment begins on February 20. The claim submitted to IME January 10 indicates the total private-pay charge. Spenddown is met.

   After spenddown is met, the IME pays $2,000. Mrs. Z is responsible for paying $500 of the $2,500 for treatment. (**Note:** If the prior approval is denied, Mrs. Z will be responsible for paying the private pay charges.)

Medical Expenses of Stepparents

Legal reference: 441 IAC 75.1(35)"g", 75.22

Use the medical expenses of stepparents who are included in the FMAP-related Medically Needy household to meet spenddown.

Use the expenses of stepparents who are not included in the FMAP-related Medically Needy household if income from the stepparent was diverted to that household. (The stepparent is considered a responsible relative.)

1. The family consists of Mrs. D, her child, and Mr. D, the stepparent. There are no common children. Mr. D, who is not disabled, is not considered in the Medically Needy group, because he would not be included in the FMAP eligible group if this were an FMAP case.

   The resources of Mrs. D and her child exceed FMAP limits but are within Medically Needy limits. Mrs. D has net countable income of $600.

   Mr. D has $1,700 earnings. There is stepparent income attributable to the household after applicable deductions and diversions. The income calculation is as follows:

$ 1,700.00	Stepparent's earnings
- 340.00	20% earned income deduction
$ 1,360.00	
- 365.00	Stepparent's needs
$ 995.00	Attributable to Mrs. D and her child
+ 600.00	Mrs. D's net countable income
$ 1,595.00	Is compared to MNIL for a household of two

   Mr. D is not included in the MN household size to determine the MNIL. However, he is entered on ABC as a financially responsible relative, so that his unpaid medical expenses are usable in meeting the Medically Needy household's spenddown.

2. Same situation as above, except that Mr. D has only $450 earnings. He has no income to attribute to the FMAP-related household of Mrs. D and her daughter. Mrs. D has net countable income of $750. His income is calculated as follows:

$ 450.00	Stepparent's earnings
- 90.00	20% earned income deduction
$ 360.00	
- 365.00	Stepparent's needs
$ 0.00	

   There is no income to attribute to Mrs. D and her child. Mr. D is not included in the Medically Needy household size to determine the MNIL. His unpaid medical expenses are not allowed as a deduction in meeting spenddown for Medically Needy group, as his income was not used to determine spenddown.

   Note: Ms. D's daughter is eligible for MAC and is a considered person for Medically Needy.

Medical Expenses Paid by a State Public Program

Legal reference: 441 IAC 75.1(35)"g"(2), (4)

Use incurred medical expenses paid **in a certification period** by a state public program (other than Medicaid) to meet spenddown. If a medical expense was paid **before** the certification period by a public program, do not allow it as a spenddown deduction.

A state public program is a program administered by the state or financed by state appropriations (including a political subdivision). A state public program does not receive any federal funding. Examples of state public programs are:

- Veteran's Assistance (soldier's relief).
- General Relief.
- Renal programs.
- AIDS/HIV health insurance premium payment program.
- State Public Health Nursing Grant.
- County nurses.
- State payment program for MH/MR/DD state cases.

Treat payments made by these programs the same as patient payments. The payment reduces the obligated medical expense when it is made before the certification period. Disregard payments when they are made within the certification period.

Mr. A's certification period is October 1 through November 30. The spenddown is $50. Mr. A verifies that he incurred a $50 physician bill on September 15. General Relief paid the $50 medical expense for Mr. A on October 1.

The General Relief payment is disregarded because it occurred during the certification period. The entire physician expense is applied towards spenddown. When the spenddown is met on the Medically Needy subsystem, Mr. A is issued a Notice of Spenddown Status (NOSS).

Medical expenses written off by a medical facility as part of its Hill-Burton commitment apply to spenddown when this was done in the certification period. Determine through discussion with the client or provider if Hill-Burton assistance was granted.

Medicare Part D

Medicare Part D is a prescription drug benefit available to Medicare beneficiaries. Enrollees in Part D may be required to:

- Pay a monthly premium.
- Pay a co-payment on each prescription.
- Meet a deductible.

Medically Needy clients who enroll in a prescription drug plan may use prescription drug expenses not covered by the plan to meet their spenddown. **Note:** Prescription drug plans vary, so costs to enrollees will be different.

Do not deduct prescriptions paid by Medicare Part D or another party from the spenddown for people who are eligible for Part D.

Deductions to Allow for Spenddown

Deduct the following expenses for spenddown for people who are eligible for Part D:

- Medicare Part D premiums the client paid.
- Prescriptions paid by the client that apply to the Medicare Part D deductible.
- Coinsurance or copayments the client paid for Medicare Part D prescriptions.
- Prescriptions paid by the client that are not paid by Medicare Part D because they are not covered in the Part D plan's formulary when the client has applied for and been denied an exception for the plan to cover the drug.
- Prescriptions paid by the client that are in a class of drugs not covered by Medicare Part D. After spenddown is met, these drugs may be Medicaid payable.
- Prescriptions paid by the client for Part D-covered drugs when the client is eligible for Part D, but has not signed up.

Applying Part D Expenses to the Spenddown

Apply Part D expenses to spenddown in the following order:

1. **Medicare Part D Premiums:** Subtract Part D premiums from the calculated spenddown on the applicable *Medically Needy Spenddown Computation Worksheet* before the spenddown is entered on ABC, along with any other health insurance or Medicare premiums.

2. **All other Medicare Part D related medical expenses:**

   - The client submits the monthly statement from the drug plan and any drug plan exception notices to you, the worker. (Prescription drug plans must issue a statement to the client at least monthly to explain all benefits paid and denied.)
   - You review the drug plan statement and circle in red the prescription expenses that should be applied to the spenddown.
   - Attach form 470-3630, *Medically Needy Transmittal*, to the completed claim form, and submit it to the IME Medically Needy Unit within five working days of receipt. The claim and transmittal can either be:
     - Faxed to the Medically Needy Unit at 515-725-1350, or
     - Mailed to: IME Medically Needy Unit, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.

Note: Advise applicants and recipients to keep their drug plan monthly statements and exception notices and to submit them to determine whether the denied drugs can be applied to the spenddown.

Personal Care Services in a Residential Care Facility

Legal reference: 441 IAC 75.1(35)"g"(2) 2

In addition to food and shelter, residents of residential care facilities may also receive personal care services from the facility. Any resident of a licensed residential care facility qualifies for this medical expense deduction. Verify the client's residence with the facility.

"Personal care services" include assistance with activities of daily living, such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication. For purposes of the Medically Needy coverage group, these personal care services do meet the definition of a necessary medical and remedial service.

The medical expenses deduction for personal care services is based on the average per day health care costs for a residential care facility, which currently is $762.74 per month. Allow $762.74 per month for the cost of medically necessary personal care services provided in a licensed residential care facility as a medical expense deduction from spenddown.

If a client is in the residential care facility for only part of the month, prorate expenses. The current personal care services per diem rate is $25.09 for the medical expense deduction. Do not allow any other facility charges (for maintenance) to meet spenddown, because a residential care facility is not classified as a medical institution.

Acupuncture Services

Legal reference: 441 IAC 75.1(3)"g"(2)4

Allow acupuncture services that are necessary medical and remedial service for spenddown. Medicaid does not cover acupuncture services.

Determining the Client's Obligation

Legal reference: 441 IAC 75.1(35)"g"

Medical expenses for which the recipient or responsible relative remains obligated to pay are allowable for spenddown. Applying an expense toward a client's spenddown is considered to meet that obligation.

Therefore, the following are **not** allowable for spenddown:

- Bills paid by Medicaid or other insurance.
- Bills used in full for spenddown previously on this case or another case.
- A paid bill incurred and used in full to meet spenddown in the retroactive period.
- A paid bill incurred in the retroactive period that was not used to meet spenddown in the retroactive period or the certification period immediately following the retroactive period.
- Bills incurred in a certification period that did not meet spenddown. These bills cannot be applied to spenddown for a subsequent certification period.

If the recipient paid with a bank loan or credit card, the recipient could be obligated to the credit card company. See Loans to Pay Medical Expenses.

When a person files bankruptcy and later signs a written agreement to pay medical bills, the person is once again obligated and the bill can be applied to spenddown. If a court assigns the person a payment plan, the bill is the person's obligation and is usable for spenddown.

Several situations that require more effort to determine the client's current obligation for medical expenses are addressed in the following sections:

- Old bills with remaining balances
- Loans to pay medical expenses
- Estimating expenses paid by insurance or another third party

Old Bills With Remaining Balances

Legal reference: 441 IAC 75.1(35)"g"; 75.22(249A)

If a client has bills that have not been paid in full but were incurred before the client was certified for Medically Needy (as conditionally eligible or eligible), apply these charges to spenddown if they were not previously used to meet a spenddown. The client must verify with a statement or bill from the provider any payments made during the certification period and the balance due.

Determine if bills that the provider turns over to a collection agency for collection are still legally obligated to the provider. If the expenses are still legally obligated to the provider, the expenses may be applied towards spenddown. Verify the status of the bill with the provider. Do not use the following for spenddown:

- Late fees or finance charges.
- Any charge no longer owed to the provider. This includes bills that the provider has written off and unpaid bills that a provider sells to a collection agency.

To apply payments made on old medical bills:

1. Total all payments before the certification period.

2. Apply payments against each charge (beginning with the oldest charge).

3. Determine if the charges exceed payments. If so, enter remaining balance on the *Medically Needy Transmittal* and attach a copy of the claim or the provider's statement. Be sure to enter the total charges on the *Medically Needy Transmittal* for that date of service and, if applicable, any payments that apply to the charge.

Attach the *Medically Needy Transmittal* to the claim for old medical bills (or to the bill, if the provider submits a bill rather than the claim). Enter the total remaining charges on the *Medically Needy Transmittal*. Highlight the remaining charges on the bill. If only a portion of the service is payable, highlight the service and indicate the remaining portion.

If the total payments exceed total charges, bills are considered paid in full and cannot be used to meet spenddown. When a medical expense was determined to be paid in full, send a manual *Notice of Decision*. Include the date of service, provider name, patient name, charge, and the reason an expense was not allowed for spenddown.

Deduct the amount applied against spenddown in the certification period from the balance due at the beginning of that certification period. When medical expenses are allowed for meeting spenddown, only the balance remaining can be applied in subsequent periods.

If a payment is made on an obligation that has been counted toward spenddown in a previous certification period that met spenddown, deduct the amount paid from the amount previously allowed as spenddown. Only the remaining value can be counted toward spenddown in the next certification period, so that deductions are not allowed once as an obligation and later as payment.

1. The G family has a March-April certification period. They have a doctor bill of $200 incurred in November that they still owe. They were not on Medically Needy when they incurred the bill. The Gs have a spenddown amount of $200 for the certification period. The family meets the March-April spenddown.

   The Gs reapply for the months of May-June. In May they pay the doctor $75 on the November bill. This payment does not count toward the May-June spenddown, because the payment is for an expense that was previously counted for spenddown.

2. The D family has a November and December certification period. They have a hospital bill of $500 from two years ago for which they are legally obligated. They were not on Medically Needy when they incurred the bill.

   The Ds have a spenddown amount of $200 for the certification period. The spenddown of $200 for November and December is deducted from the $500 bill, leaving $300 that can be applied to future certification periods.

   The Ds make a $200 payment on December 26 after spenddown was met. They are recertified for January and February. The worker indicates on the payment section of the BSTD that a payment of $200 was made on December 26.

   The Medically Needy subsystem applies this payment to the amount that was previously used to meet spenddown. The worker resubmits the BSTD to have the remaining value of $300 applied to the January-February certification period.

3. The E family received a bill for a non-Medicaid-covered service of $1,000 in January. The family was certified for January and February with a $400 spend-down. The potential remaining value of the bill is $600.

The family is recertified for March and April with a $500 spenddown. The family still owes $600 on the non-Medicaid-covered service, which is applied to the spenddown for the March-April certification period. The potential remaining value of the bill to be applied to the next certification period is $100.

The family is recertified for the May and June certification period with a spend-down of $400. The remaining value of $100 is applied to the spenddown, as it still remains obligated. The family incurs $200 more in medical expenses for May and June, which are also applied to spenddown.

The family does not meet spenddown for the May and June certification period. Even if the total $300 in bills remains unpaid, these bills **cannot be carried forward** to the next certification period.

Loans to Pay Medical Expenses

Legal reference: 441 IAC 75.1(35)"g"

The balance of a loan used to pay medical expenses for a member of the Medically Needy group or a responsible relative may be used to meet spenddown. Loans include repayment arrangements with financial institutions, credit card companies, private individuals, etc. Do not allow accrued interest or any portion of the loan obtained and used for purposes other than for medical expenses.

If an incurred medical expense that has been paid by a loan has been previously submitted for meeting spenddown for the retroactive period, apply only the remaining value of the medical expense to the two-month certification period immediately following the retroactive certification period.

If an incurred medical expense paid by a loan has been previously submitted and spenddown was met, apply only the remaining value of the medical expense to the subsequent certification period.

As of the first day of the certification period, consider for meeting spenddown the portion of the loan balance that:

- Remains obligated and
- Was used to pay allowable incurred medical expenses for a member of the medically needy group or a responsible relative.

To consider the loan as a medical expense:

1. Verify that the loan was for medical expenses. Examine the repayment or loan document or obtain a statement from the financial institution.

   If the loan was not made by an institution, obtain a statement signed by both parties describing the obligation to repay. This statement does not necessarily have to have been drawn up when the loan was received. A current statement from both parties is enough to verify that an obligation exists to repay the loan.

2. Verify what payments have been made on the loan before the beginning of the certification period.

   The client may have paid medical expenses by using a credit card. If the client pays a portion of a credit card bill, count the first expense incurred as the first paid off. If expenses were incurred on the same day, apply the payment to the advantage of the client.

   For example, if the client incurred a bill for a medical expense and another non-medical expense on the same day, apply the payment to the non-medical expense. This allows the medical expense to be used for spenddown.

3. Deduct any interest from the payments made on the loan.

4. Gather information regarding the medical expense paid in order to record the incurred medical expense in the comment section of the *Medically Needy Transmittal*.

5. Calculate the balance of the medical expense portion of the loan as of the first day of the certification period.

6. Enter in the comment section of the *Medically Needy Transmittal* any payments made on the loan before the certification period and during the certification period. Enter on the *Medically Needy Transmittal* all payments made directly on the bill (payments other than from the loan).

7. For resubmittal of the medical expenses, record any principal payments made since the last determination on the *Bill Status Turnaround Document* (BSTD).

Record all payments toward the incurred medical expense other than payments made from the loan. Determine what the balance of the loan was as of the first day of the certification period. This may involve requesting verification from the financial institution of what the unpaid balance was on that date.

Deduct the balance as of the first of the certification period from the original loan balance. This reflects the reduction of the principal from the loan date to the beginning of the certification period. Record this difference on the *Medically Needy Transmittal* as a payment made before the certification period.

If the bill is resubmitted for use in meeting a future spenddown, again determine the loan balance for the medical expense as of the first day of the new certification period. Again record the difference between these two balances as a payment before this latest certification period.

1. On November 10, Mrs. M gets a loan to pay off the $3,000 remaining balance of a medical expense. The total charge was $5,000 and was incurred for her hospitalization of October 10 through October 20. Insurance paid $2,000 on November 1.

   On March 1, Mrs. M learns of the Medically Needy program and applies for current Medicaid coverage. The IM worker establishes a March-April certification period with a spenddown of $200.

   Mrs. M brings in verification of the October hospitalization, a copy of the loan agreement, and verification that the hospital bill was paid in full. She reports that she made three $50 payments ($150) on the loan before March 1. The IM worker records the total hospitalization expenses ($5,000) in the comment section of the *Medically Needy Transmittal.*

   The payment that is indicated on *Medically Needy Transmittal* reflects the $2,000 paid on November 1 by insurance. To determine the amount of payment that was incurred to pay medical expenses, the worker views the client's loan payment book. On March 1, the current balance was $2,900. ($3,000 original loan balance minus $2,900 equals $100.)

   The worker records a $100 payment on the *Medically Needy Transmittal* with a date before the start of the certification period (March 1). Even though Mrs. M made $150 in payments on the loan, only $100 was paid on the original medical expense. The remaining $50 was for interest, which is not an allowable deduction.

The claim is attached to the *Medically Needy Transmittal* and sent to the IME. The comment section includes the following information:

10/10 - 10/20	Total charge	$5,000
11/1	Insurance payment	$2,000
Before 3/1	Client payment	$100
	Loan balance as of March 1	$2,900

2. Mr. D, age 20, is hospitalized from December 1 through December 4 and incurs a medical expense of $2,000. He has no health insurance coverage. He has savings of $500, which he decides to use towards his hospital bill. To pay the balance of the bill, Mr. D goes to his credit union and takes out a loan for $1,500 on December 10. He pays the hospital in full on December 11.

   On December 20, Mr. D learns that he may be eligible under the Medically Needy program. On December 24, he applies for Medicaid and explains that he paid for his hospitalization by taking out a loan. He further explains that the hospital has told him that if he becomes Medicaid-eligible, the hospital will reimburse him the payment he has made minus any spenddown obligation that may be established.

   The IM worker approves Mr. D as potentially eligible for Medically Needy for a December-January certification period. He has a spenddown of $350.

   The hospital submits a claim to the IME for use in meeting Mr. D's spenddown. The payment made to the hospital by the proceeds of the loan is not recorded. (Since this medical expense was incurred within the certification period, the computer disregards client payments.)

   Mr. D meets the spenddown and cards are issued. The hospital refunds Mr. D all but $350 of his payments made in December, and <u>then</u> the hospital bills Medicaid.

3. Ms. J, age 20, incurs a medical expense with Dr. N on January 2 for $50. She pays this bill in full with her newly obtained MasterCard. (This is the first bill she paid with her MasterCard.) On June 10, Ms. J applies for Medicaid and is conditionally approved with a $50 spenddown for the June through July certification period.

   Between January 10 and June 10, Ms. J used her MasterCard to pay for $500 in nonmedical expenses. She inquires whether the medical expense she paid by MasterCard is usable toward meeting her spenddown.

   The IM worker verifies that Ms. J made four $20 payments on her MasterCard before June 1. This total payment of $80 exceeds the $50 charge plus interest that was first incurred on MasterCard. The IM worker informs Ms. J that there is no unpaid balance of the $50 charge remaining. Therefore, there is no medical expense to be submitted toward meeting her current spenddown.

Expenses Paid by Insurance or Third Party

Legal reference: 441 IAC 75.1(35)"f," 75.1(35)"g"

When the client has other health insurance coverage and either the provider or the IM worker submits a claim to the IME, the claim must reflect the third-party insurance information and payment, when applicable. The IME will deny payment on claims that do not reflect this information.

It is not your responsibility to make sure the claims carry insurance information. Forward the claim to the IME as submitted. The IME will make a determination regarding third-party insurance involvement.

See the following sections for more information on:

- Clients who have Medicare and QMB
- Estimating Medicare Part A payments
- Estimating Medicare Part B payments
- Changes or corrections to insurance payments

Clients Who Have Medicare and QMB

Legal reference: 441 IAC 75.1(35)"g," 75.52(5)

If the client has Medicare and is also eligible for QMB, do not use Medicare claims to meet the spenddown. QMB pays Medicare premiums, deductibles, and coinsurances. The provider will submit the claim to Medicare for payment. Medicare crosses the claim over to Medicaid for payment.

Medicare Part A Payments

Legal reference: 441 IAC 75.1(35)"g," 75.52(5)

If the client has Medicare coverage and is not eligible for QMB, the client may need to meet the Medicare Part A deductible of $1,068. If the deductible has not been met, the Medicare Part A deductible is used to meet the spenddown.

The provider submits the claim to Medicare for payment. Medicare sends the claim to Medicaid for payment of the deductible amount. This is called "crossover" from Medicare to Medicaid.

Medicare Part A includes the following services:

- Inpatient hospital charges (room and board, general nursing, and miscellaneous hospital services and supplies).
- Care in a skilled nursing facility following a hospital stay.
- Home health care for a homebound person. If the client does not have Medicare Part A, then home health care can be paid under Medicare Part B.
- Hospice care for terminally ill persons.

Medicare Part B Payments

Legal reference: 441 IAC 75.1(35)"g," 75.52(5)

If the client has Medicare Part B and is not eligible for QMB, the client may need to meet the Medicare Part B deductible of $135. If the Medicare Part B deductible has not been met, the deductible is used to meet spenddown.

Use the following services to meet the Medicare Part B deductible:

- Physician services.
- Physician charges for inpatient and outpatient medical and surgical services and supplies.
- Physical and speech therapy.
- Ambulance services.
- Diagnostic tests, such as X-rays.
- Outpatient hospital treatment.
- Blood.
- Durable medical equipment.
- Home health care for the homebound if the client does not have Medicare Part A.
- Clinical laboratory services, such as blood tests, urinalyses, biopsies, etc., provided by a Medicare certified laboratory.

The provider submits the claim to Medicare for payment. Medicare submits the claim to Medicaid for payment of the deductible amount or copayment amount. This is called a "crossover" from Medicare to Medicaid. The IME submits the claim to the Medically Needy subsystem for spenddown consideration if the client has a copayment or deductible to pay.

Changes or Corrections on Payments

Legal reference: 441 IAC 75.1(35)"g"

Make changes or corrections when there is a change in insurance coverage.

If the client verifies that the client no longer has Medicare, complete form 470-0397, *Request for Special Update*, and send it to Quality Assurance.

If the client no longer has insurance, complete a *Supplemental Insurance Questionnaire* (SIQ) and indicate the date insurance was terminated. Send the SIQ to the IME Third Party Liability (TPL) Unit. A special update is not required if the date the insurance terminated is on the SIQ.

Do not send the claim and *Medically Needy Transmittal* unless the SIQ has been sent to the IME TPL Unit. Indicate on the *Medically Needy Transmittal* that the client no longer has insurance and that the SIQ has been sent. The address of the IME TPL Unit is P.O. Box 36475, Des Moines, IA 50315. The TPL Unit fax number is (515) 725-1352.

Order of Deducting Expenses for Spenddown

Legal reference: 441 IAC 75.22 (249A); 75.1(35)"f"; 75.1(35)"g"

To meet spenddown, deduct medical expenses in the following order:

1. Health insurance premiums. (These are deducted when calculating the spenddown.)
2. Deductibles, coinsurance, or Medicaid copayments, if they remain unpaid.
3. Expenses for necessary medical and remedial services **not covered** under the Medicaid program chronologically by date of submission. (See Noncovered Medicaid Services.)

4. Expenses for necessary medical and remedial services covered by Medicaid. A responsible relative's expenses are deducted before those of a conditionally eligible person chronologically by date of submission.

The chart on this page shows the order of deducting bills in the Medically Needy subsystem, as well as the priority within that order. Try to process bills or claims for old bills immediately at the beginning of the certification period, so that they can be applied before current bills.

Type (in priority order)	**Priority of Consideration**
1. Bills paid in the retroactive period	Apply the balance of the bill that was not used to meet spenddown in the retroactive period to the spenddown of the certification period immediately following the retroactive period.
2. Credits	A credit occurs when a nonpayable bill was used to meet spenddown in previous certification period, but then was deleted from spenddown for that period. Use only if the nonpayable bill remains obligated.
3. Nonpayable bills: Old bills Responsible relative bills Non-Medicaid providers Not payable by Medicaid	A. Apply a bill paid in full by the client or a state public program in or after the certification period. B. Apply the paid portion of a bill partially paid by the client or a state public program other than Medicaid in or after the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.
4. Medicaid-payable bills incurred within the certification period	A. Apply a bill paid in full by the client or state public program in the certification period. B. Apply the paid portion of a bill partially paid by the client or state public program in the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.

Removing Expenses Previously Deducted

Legal reference: 441 IAC 75.1(35)"g"

When a provider submits a claim to the IME that would be payable by Medicaid but spenddown has not been met, the claim is used to meet spenddown.

However, if a bill or claim for a service that is not Medicaid-payable is received after spenddown has been met **and** the service on the bill or claim has a higher priority than the Medicaid-payable claim occurring in the certification period (see chart: Priority of Consideration), the Medicaid-payable claim needs to be removed or "backed out" of the Medically Needy subsystem.

To back out a claim, the noncovered service must have occurred before the spenddown was met. Do not request to back out a claim for the eligible person when a bill or claim is received for a service that occurred after spenddown is met.

After the Medicaid-covered service is backed out of the Medically Needy subsystem, it is Medicaid-payable. See 14-I, SPECIAL PROCEDURES, for instructions on backing claims out of the Medically Needy subsystem.

Mrs. B has a spenddown of $75 for the July-August certification period. She indicates to the worker that she has a $500 medical bill that she owes.

The notice of decision is sent July 15. Mrs. B goes to the pharmacy on July 16. Her prescriptions cost $85. The pharmacist submits a point-of-sale claim for $85 on July 16 and is informed that the client has a spenddown to meet. The claim is denied and submitted for spenddown consideration.

Mrs. B meets spenddown on July 17.

On July 20, the worker receives a claim for a service not payable by Medicaid that occurred before Mrs. B was certified for Medically Needy. The worker sends a copy of the claim and *Transmittal* to the IME Medically Needy Unit, requesting that the pharmacy bill be backed out and the older bill be used to meet spenddown.

A *Notice of Spenddown Status* (NOSS) is sent to the worker. The worker sends the NOSS to the client. This notifies the client that the pharmacy bill is now Medicaid-payable. The IME reimburses the pharmacy. The pharmacy reimburses the client.

ACTING ON CHANGES

Legal reference: 441 IAC 75.52(5)

A change reported by the client during the certification period is effective the first day of the next calendar month if timely notice is not required and the certification period has not expired.

If timely notice is required, make the change effective the first day of the month following timely notice if the certification period has not expired.

If a client becomes eligible under another coverage group during the certification period, redetermine eligibility.

1. Certification period November and December

Net income	$600	+	$600	=	$ 1,200
MNIL	$483	+	$483	=	- 966
					$ 234 Spenddown

Change: On November 24, the F family files an application for FIP and FMAP because Mr. F lost his job. A *Notice of Decision* issued December 15 states that eligibility exists for FIP and FMAP effective December 1. (The family is still over income for FMAP in November.)

Certification period	November
Net income	$ 600
MNIL	- 483
	$ 117 Spenddown

If incurred medical expenses equal or exceed $117 in November, the family is eligible as Medically Needy. Since the family is eligible for FIP and FMAP in December because of decreased income, the family is no longer eligible under the Medically Needy program.

2. Same situation as Example 1, except the family had already met spenddown for the November-December certification period. Follow procedures in 14-I, SPECIAL PROCEDURES: Deleting Claims: Decrease in Spenddown for a Frozen Period.

For Medically Needy households that are also on other programs, act on changes that are reported on that program's report form.

See 8-G, Reporting Changes, for changes that need to be reported.

Effect on Spenddown

Legal reference: 441 IAC 75.52(5), 75.52(4)"e"

When a change is reported, recalculate spenddown unless the change is reported timely in the last month of a certification period. If the change was not reported timely, do a recoupment if the spenddown increases.

Mr. S	(No income)
Mrs. S	($2,000 earned income)
Child W	
Child X	

Mr. S leaves the home February 18 during the February-March certification period. The change is reported to the local office February 22. By removing Mr. S, the spenddown increases, as there is one less person to consider for the MNIL. Timely notice is required to remove Mr. S from the case. There is no recoupment for March.

Adding An Excluded Person to the Household

Do not add the excluded person to household for the excluded month. If the household requests, the person may be added the following month, regardless of the date of the request in the excluded month.

If the excluded person is added after timely notice and the spenddown increases, do a recoupment for the additional spenddown amount.

If the excluded person is added before timely notice and the spenddown increases follow the instructions in 14-I, SPECIAL PROCEDURES: Increasing Spenddown.

Increase in Spenddown

Legal reference: 441 IAC 75.52(5)

Changes that are reported or discovered may increase a spenddown amount that has previously been entered in the Medically Needy subsystem. Do not establish eligibility for the succeeding months of the certification period until difference between the original spenddown amount and the new spenddown amount has been met.

If spenddown for the certification period has not been met, changes in the spenddown may be made on the ESTD, provided timely notice can be issued to the household.

If there is a zero spenddown or if spenddown has been met, spenddown cannot be changed on the Medically Needy subsystem. If spenddown has been met:

1. Cancel the original case on the ABC system, using the zero notice reason.

2. Change the fund codes to "9" for people coded with an S or P on the ESTD for the subsequent month.

3. Establish a new FBU to reflect the corrected spenddown amount for the subsequent month. The difference between the new and the original spenddown amount is the amount of spenddown entered on the new FBU.

4. Payable bills from a prior period cannot be used to meet spenddown for the second month of the certification period that has been established on the new FBU.

1. Certification period: November & December

Net income	$540	+	$540	=	$1,080
MNIL (1 person)	$483	+	$483	=	- 966
					$ 114 Spenddown

Change: On November 10, the SSI-related conditionally eligible person reports a $50 increase in income. Spenddown for the November-December certification period has not been met. The IM worker recalculates as follows and sends timely notice:

Certification period: November & December

Net income	$540	+	$590	=	$1,130
MNIL (1 person)	$483	+	$483	=	- 966
					$ 164 Spenddown

New spenddown	$164	
Original spenddown	-114	
	$ 50	Additional spenddown for December

The IM worker changes the spenddown amount to $164 on the ESTD and sends the ESTD to the IME Medically Needy Unit.

2. The SSI-related case has a April-May certification period with a spenddown of $155. On April 10, an increase in income is reported. The new spenddown is $250. The difference is $95. The IM worker checks the Medically Needy subsystem and discovers that spenddown was met on April 9. Therefore, the certification period is frozen.

   The IM worker issues a timely notice of decision effective May 1 informing the client of the new spenddown. Since it is before April timely notice, the IM worker cancels the Medically Needy case effective May 1. The IM worker changes the ESTD for May, using a fund code of 9 for persons coded with an S or P.

   Once the case is canceled and the ESTD has been corrected, the IM worker establishes a new FBU for the month of May only with the new spenddown amount of $95 (the difference between the new spenddown amount and the previous spenddown that was met). The IM worker ensures that the bills used previously to meet spenddown are not allowed on the new FBU.

   The IM worker establishes the June-July certification period for using the original FBU.

3. In a May-June certification period, spenddown is met May 5. Due to a reported change, the IM worker establishes a separate FBU for the month of June. The spenddown for June is $55.

   A provider submits a claim showing charges for May 30. Once spenddown was met, the client became eligible for Medicaid in May. These charges are Medicaid-payable and do not represent a legal obligation. Therefore, the May bill cannot be used to meet spenddown for the June-only certification period. Allowable medical bills incurred in June are used to meet spenddown for that month.

If a change results in a **spenddown for a case that did not have a spenddown**, assign a two-month certification period. Provide timely notice of the conditionally eligible status, the amount of spenddown, and the months of the certification period.

If the timely notice deadline has passed and the change cannot be made for the certification period, follow recoupment procedures for those errors made by the worker or due to untimely reporting by the household.

Use old medical bills that are not payable in a prior period and remain legally obligated to meet spenddown. See 14-I, Resubmittals, for instructions on when to resubmit bills on the *Bill Status Turnaround Document.*

If the change results in a **decrease in spenddown**, recalculate the spenddown. Enter the change on the ESTD regardless of whether spenddown has been met. Send the ESTD to the IME Medically Needy Unit, Hoover Building, Des Moines.

A *Notice of Spenddown Status* and *Bill Status Turnaround Document* will be generated indicating the changes for the certification period.

If bills payable by the Medicaid program were used to meet spenddown the claims will be deleted from the Medically Needy subsystem and paid.

If a nonpayable bill used to meet spenddown is still unpaid, a credit will be indicated on the *Bill Status Turnaround Document*.

Provide notice to the client of the new spenddown amount.

1. February-March Certification Period

Mr. M	($2000 earned income)
Mrs. M	($ 500 UIB)
Child W	
Child X	

Mr. M leaves the home on February 4. This is reported February 15. The county office is not required to issue timely notice, as the overall program effect is positive. Mrs. M continues to be eligible for March with a reduced spenddown. The children are determined eligible for MAC and are considered persons for Medically Needy.

The IM worker sends a *Notice of Decision* indicating a decrease in spenddown and changes the spenddown amount on the ESTD. The IM worker also sends a *Notice of Decision* on MAC eligibility for the children.

2. Household composition: Mr. T, age 20, and Mrs. T, age 19. The case is CMAP-related.

   Mr. T receives $462 unemployment benefits per month. Mrs. T receives $50 worker's compensation per month. The date of decision is November 1.

Certification period	November	and	December			
Net income	$512	+	$512	=	$ 1,024	
MNIL for two	$483	+	$483	=	$ 966	
				=	$ 58	Spenddown

   Mr. T timely reports on November 21 (the first month of the certification period) that Mrs. T has left the home and has filed for divorce. On November 28, the IM worker acts upon the reported change and recalculates the spenddown as follows:

	November		December			
Net income	$512	+	$462	=	$ 974	
MNIL for two	$483					
MNIL for one		+	$483	=	$ 966	
				=	$ 8	Spenddown

   The reported change has a positive effect on the spenddown (it reduces it). The IM worker sends a notice informing Mr. T that his spenddown has been reduced to $8 and changes the amount on the ESTD.

3. Mr. Q's (SSI-related) spenddown for the November-December certification period was calculated as follows:

Certification period	November	and	December			
Net income	$450	+	$534	=	$ 984	
MNIL	$483	+	$483	=	$ 966	
					$ 18	Spenddown

   On November 20, Mr. Q reports his December income will be only $450. Spenddown is recalculated as follows:

Certification period	November	and	December			
Net income	$450	+	$450	=	$ 900	
MNIL	$483	+	$483	=	$ 966	
					$ 0	Spenddown

   The IM worker sends a *Notice of Decision* informing Mr. Q that there is no longer a spenddown obligation for the November-December certification period and changes the amount on the ESTD.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

May 20, 1997

GENERAL LETTER NO. 8-J-42

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Title page, revised; Contents (pages 1 through 3), revised; pages 1 through 102, revised; and pages 103 through 106, new.

Summary

This general letter transmits the revised 8-J, ***Medically Needy***. The existing chapter is reorganized and rewritten to incorporate the Department's updated manual format and writing style.

This chapter has been revised to reflect the 1997 Social Security cost of living allowance (COLA) increase of 2.9%.

Contained within this chapter is a change to policy regarding projecting income under the SSI-related Medically Needy coverage group. SSI-related Medically Needy will follow general SSI policy, which states that weekly income can be converted to monthly income by multiplying by 4.3 and biweekly income can be converted to monthly income by multiplying by 2.15.

Effective Date

Upon receipt.

Material Superseded

Remove all existing pages from Employees' Manual, Title VIII, Chapter J, and destroy them. This includes:

Page	Date
Title page	November 13, 1984
Contents (pages 1 through 3)	Various dates
1-102	Various dates

Also obsolete the following interpretive memos:

MS-VIII-88-3, "Composite ADC/MN Cases with Newborn and Stepparent"
MS-VIII-89-4, "Untitled"
MS-VIII-89-24, "Medicaid through the Medically Needy Program for the Institutionalized"
MS-VIII-90-2, "The Prior Approval Process and the Medically Needy Program"
MS-VIII-91-4, "1619b Eligibility and Spenddown Determination"

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

June 17, 1997

GENERAL LETTER NO. 8-J-43

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Contents (pages 2 and 3), revised; pages 25, 68, 69, 73, and 100, revised; and pages 72a, 72b, and 100a, new.

Summary

As of July 1, providers may submit Medicaid-covered expenses that occur during the certification period for conditionally eligible and for responsible relatives on a claim form directly to the fiscal agent, Consultec. If the provider submits a claim to Consultec, the spenddown process will be faster for clients who have only current medical expenses.

The provider may also choose to submit the Medicaid-covered expenses that occur during the certification period on the *Medical Expense Verification* (MEV) form to the IM worker. Expenses that occurred before the certification period or noncovered Medicaid expenses continue to be submitted on a MEV.

When spenddown has not been met, Consultec will inform the provider that the claim has been denied and that the claim was submitted for spenddown. Consultec will submit the information on the claim electronically to the Medically Needy Spenddown Control (MNSC) system.

Spenddown may already have been met with a Medicaid-covered service submitted on a claim to the fiscal agent when you receive a MEV. If the MEV is for a noncovered service that was incurred earlier than the Medicaid-covered service that expense has priority. All or a portion of the Medicaid-covered service may need to be "backed out" of the MNSC system. After the Medicaid-covered expense has been backed out, it will become Medicaid-payable.

A person disqualified for the Family Investment Program because of intentional program violation may still be eligible for Medicaid.

Effective Date

July 1, 1997

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (pages 2 and 3)	May 20, 1997
25, 68, 69, 73, 100	May 20, 1997

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

September 9, 1997

GENERAL LETTER NO. 8-J-44

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, page 85, revised.

Summary

The cost for personal care services in a residential care facility has increased.

Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $384.26.

Effective Date

October 1, 1997

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, page 85, dated May 20, 1997, and destroy it:

Additional Information

Please contact your regional benefit payment administrator if you have questions.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

January 13, 1998

GENERAL LETTER NO. 8-J-45

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Title page, revised; Contents (pages 1-3), revised; and pages 1 through 106, revised; and page 107 new.

Summary

Before the passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRW0A), people who received cash assistance under the Family Investment Program (FIP) was automatically eligible to receive Medicaid unless they had a Medicaid qualifying trust or had transferred assets. Due to the new five-year lifetime limit to receive cash assistance, the PRWOA removed the link between FIP and Medicaid, so that a person's eligibility for Medicaid was not dependent upon receipt of cash assistance.

The Family Medical Assistance Program (FMAP) replaces the coverage group for people who previously received Medicaid because they received FIP. Medicaid coverage groups for families and children will no longer be referred to as "FIP-related" but will now be referred to as "FMAP-related."

Cross references to Chapters 8-D, ***Resources***, and 8-E, ***Income***, have been added to the chapter. However, revisions to these chapters are not yet completed. Continue to follow FIP-related policy in Title 4 in addition to current Medicaid policy, as appropriate, until such time as the FIP income and resource polices are incorporated into Title 8.

Legal references have been changed.

There are changes for the implementation of the X-PERT system. The changes include new application forms and changes in the application process for households selected for the X-PERT system.

Effective Date

The changes as a result of delinking are effective retroactively to December 1, 1997.

The X-PERT changes are effective upon implementation in the counties.

All other changes are effective upon receipt.

Material Superseded

Remove the entire Employees' Manual, Title 8, Chapter J, and destroy it. This includes:

Page	Date
Title page	May 20, 1997
Contents (page 1)	May 20, 1997
Contents (page 2 and 3)	June 17, 1997
1-24	May 20, 1997
27-67	May 20, 1997
68, 69	June 17, 1997
70-72	May 20, 1997
72a, 72b, 73	June 17, 1997
74, 76, 78-84	May 20, 1997
85	September 9, 1997
86-99	May 20, 1997
100, 100a	June 17, 1997
101-106	May 20, 1997

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

September 8, 1998

GENERAL LETTER NO. 8-J-46

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, page 85, revised.

Summary

The cost for personal care services in a residential care facility has increased.

Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $560.58.

Effective Date

October 1, 1998

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, page 85, dated January 13, 1998, and destroy it:

Additional Information

Please contact your regional benefit payment administrator if you have questions.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

October 6, 1998

GENERAL LETTER NO. 8-J-47

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Contents (page 2), revised; and pages 1, 14 through 17, 33 through 42, 45, 46, 49, 52, 53, 54, 56 through 62, 65, 68, 69, 73, 74, 79, 83, 84, 99, 100, and 106, revised.

Summary

The chapter has been revised to:

- Reflect the 1998 Social Security cost of living allowance (COLA) increase of 2.1%.
- Include the relationship of expanded SLMB and home health SLMB eligibility to Medically Needy eligibility.
- Delete the reference to children born after September 30, 1993, from examples.
- Allow a MEV or Medicaid claim to be submitted up to 12 months after the certification period ended for meeting the client's spenddown.
- Allow an adjustment (back out) to spenddown when an unpaid Medicaid covered service has been used to meet spenddown, and a service paid by the client is received after the spenddown was met. The unpaid claim may be backed out of the MNSC system only if the paid bill for a service is incurred in the certification period with a date before the notice of decision.
- Add state payment programs and county nurses as examples of the state public program.

Effective Date

COLA increases and relationship of E-SLMB and HH-SLMB are effective January 1, 1998.

The reference to children born after September 30, 1998, is effective July 1, 1998.

State payment program change effective upon receipt.

All other changes effective November 1, 1998.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Table of Contents (page 2), 1, 14-17, 33-42, 45, 46, 49, 52-54, 56-62, 65, 68, 69, 73, 74, 79, 83, 84, 99, 100, 106	January 13, 1998

Additional Information

Please contact your regional benefit payment administrator if you have questions.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

December 15, 1998

GENERAL LETTER NO. 8-J-48

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, pages 50 through 54, 56 through 61, 65, 66, 69, 70, 94, 95, 96, 101, and 105, revised.

Summary

This chapter has been revised to reflect:

- The 1999 Social Security cost of living adjustment (COLA) increase of 1.3%.
- The 1999 Medicare Part B premium increase.
- The 1999 Medicare Part A deductible increase.

Effective Date

January 1, 1999

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
43, 44, 50, 51	January 13, 1998
52-54, 56-61, 65	October 6, 1998
66	January 13, 1998
69	October 6, 1998
70, 94-96, 101, 105	January 13, 1998

Note: Instructions to delete pages 43 and 44 were inadvertently omitted from General Letter 8-J-47, issued October 6, 1998.

Additional Information

Please contact your regional benefit payment administrator if you have any questions.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 15, 1999

GENERAL LETTER NO. 8-J-49

ISSUED BY: Bureau of Medicaid Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Table of Contents (pages 1-3), pages 3, 6, 9, 13, 15 through 18, 22, 29, 30, 33, 34, 35, 37, 39 through 42, 46, 52, 66, 67, 70 through 77, 82, 84, 85, and 87 through 105, revised; and pages 18a and 52a, new.

Summary

The MNSC system is being transferred to the MMIS Medically Needy subsystem at Consultec. The following changes will occur with this transfer:

- The *Medical Expense Verification* form will be eliminated.
- Providers will submit claims to Consultec for all Medicaid-covered services that occurred during the certification period. If only a portion of the claim is used to meet spenddown, payment for the appropriate amount will be paid to the provider after eligibility has been updated on REVS. The provider will not need to resubmit the claim for payment. Any Medicaid-payable claims that were submitted and not used to meet spenddown will be paid.
- The clients or provider will submit claims for old bills or non-Medicaid-payable claims to the IM worker. The IM worker will complete and attach the *Medically Needy Transmittal*, form 470-3630, to the claim. Keep a copy of the claim and transmittal in the client's case file. If the provider submits a statement for the bill, in lieu of the claim form, this may be attached to the transmittal. The IM worker will need to determine the amount of this bill that is usable towards spenddown.
- For transportation costs and for personal care services in an RCF, the worker enters the amount of expenses on the *Medicaid Needy Transmittal* and sends it to Consultec's Medically Needy Unit.
- The IM worker sends the claim forms to Consultec's Medically Needy Unit within five days of receipt or sooner. Sending these as soon as possible upon receipt will help to reduce the need for backing out Medicaid-covered services that occurred during the certification period.

- A backout will occur when a Medicaid-covered expense is used to meet spenddown before the receipt of an old bill or a non-Medicaid-covered service that occurred before spenddown was met on the MMIS Medically Needy subsystem.

  When this occurs send Consultec the claim for the old bill or non-Medicaid-covered service. Attach the *Medically Needy Transmittal*. Indicate in comments that this is a back out. The MMIS Medially Needy subsystem will back out the Medicaid-covered service that occurred during the certification period. The backed out claim will then be sent to MMIS for payment.

- The MMIS Medically Needy subsystem will issue ESTDs, BSTDs, NOSS, and Medically Needy Error Reports.

  Consultec will send the ESTD when a certification period is created on the Medically Needy subsystem and after an ESTD has been submitted and updated.

  The BSTD and the NOSS will be sent biweekly to the worker when a claim has been submitted on the case and spenddown has not been met. The BSTD and the NOSS will continue to be sent when spenddown has been met.

- Providers may call REVS to verify the amount of the client's spenddown. REVS will nightly update and report the remaining spenddown amount as claims are accumulated to meet the spenddown.

- MMIS Medically Needy subsystem notifies the IABC system that spenddown has been met and notifies REVS that the remaining amount of the spenddown is $0. IABC issues the eligibility cards and notifies the fiscal agent that the client is eligible. REVS is updated to indicate that the client is Medicaid eligible.

- When submitting claims, the IM worker will no longer estimate expenses paid by a third party. For clients who have other health insurance coverage or Medicare, if the claim does indicate an insurance payment, Consultec will return the claim to the provider or will estimate the client's copayment to be 20 percent.

When medical expenses are submitted to the MMIS Medically Needy subsystem, both necessary medical and remedial services not covered under the Medicaid program and necessary medical and remedial services covered by Medicaid will be entered chronologically by the date of submission. In the order of deducting expenses for meeting spenddown, necessary medical and remedial services not covered under the Medicaid program have a higher priority than services covered by Medicaid.

If spenddown was met with a Medicaid-covered service and a non-Medicaid-payable claim that occurred before the date that spenddown was met is later received, submit the claim with the transmittal to Consultec's Medically Needy Unit. The Medicaid-covered claim will be backed out and the appropriate amount will be paid to the provider.

Allow acupuncture services that are a necessary medical and remedial service for spenddown. Acupuncture is not a Medicaid-covered service.

The 78th session of the Iowa Legislature directed the Department not to require a face-to-face interview at the time of the initial interview or at the time of recertification in determining Medicaid eligibility for persons under age 21. An interview is required in determining Medicaid eligibility for adults.

The 78th session of the Iowa Legislature directed the Department to disregard the resources of all responsible relatives and eligible or conditionally eligible persons living together when determining eligibility for FMAP-related, CMAP-related, or SSI-related children under age 21.

Additional information has been added to clarify the following:

- Examples have been changed and added to reflect current policy.
- Include a CMAP-related child with the parents on Medically Needy case if the parents are FMAP-related. If the parents are not on FMAP, the parents are considered self-supporting parents. Therefore, use the parents' income to determine eligibility of the CMAP-related child.
- The necessary items to be included in a Notice of Decision for an SSI-related person who has ongoing eligibility are listed.

Effective Date

The following changes are effective July 1, 1999:

- Eliminating the face-to-face interview for children.
- Disregarding resources for children.
- Allowing acupuncture for meeting spenddown.
- Moving the MNSC system to Consultec's MMIS Medically Needy subsystem.
- Eliminating the use of the MEVs.
- Using medical expenses chronologically by date of submission for meeting spenddown.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Table of Contents (page 1)	January 13, 1998
Table of Contents (page 2)	October 6, 1998
Table of Contents (page 3)	January 13, 1998
3, 6, 9,13	January 13, 1998
15-17	October 6, 1998

18, 22, 29, 30	January 13, 1998
33-35, 37, 39-42, 46	October 6, 1998
52, 66	December 15, 1998
67	January 13, 1998
70	December 15, 1998
71, 72	January 13, 1998
73, 74	October 6, 1998
75-77, 82	January 13, 1998
84	October 6, 1998
85	September 8, 1998
87-93	January 13, 1998
94-96	December 15, 1998
97, 98	January 13, 1998
99, 100	October 6, 1998
101	December 15, 1998
102-104	January 13, 1998
105	December 15, 1998
106	October 6, 1998
107	January 13, 1998

Implementation

Do not give MEVs to clients whose certification period begins with the month of July.

On June 28, begin sending the claim forms for old bills and non-Medicaid-payable bills to Consultec. When sending these claims to the Consultec's Medically Needy Unit, complete and attach the *Medically Needy Transmittal*, form 470-3630.

Any MEV not processed by June 28 or received after June 28 should be sent to Consultec's Medically Needy Unit. Send local mail to Consultec's Medically Needy Unit, Central Office, using a DHS route slip or local mail envelope.

On June 28, IM may begin contacting Consultec's Medically Needy Unit in the following situations:

- Emergency corrections of ESTDs or BSTDS.
- Adding a retroactive certification period when the current certification period is on the MMIS Medically Needy subsystem.
- Correcting bills.

The telephone numbers for Consultec's Medically Needy Unit are:

Local:	515-327-5125
Toll free:	800-270-7234
Fax:	515-327-0945

Do not call Consultec's Medically Needy Unit for assistance with Medically Needy policy questions or IABC questions. Go through the normal channels for Medically Needy policy questions. Call the HELP desk for IABC questions.

June 30 will be the last day that Medically Needy Spenddown Control System will be available for use.

DHS will send BSTDs, NOSSs, ESTDs to IM on July 1 from the last cycle run on June 30 for processing medical expenses for spenddown on the MNSC system.

Consultec will convert the information on the MNSC system to MMIS Medically Needy subsystem beginning July 1 and finishing July 5,

On July 5, the first Medically Needy subsystem nightly production cycle will run Medicaid covered services that the providers have submitted to Consultec.

On July 6, the first Medically Needy subsystem will generate ESTDs, if spenddown was met BSTDs and NOSS will be generated.

On July 6, Consultec's Medically Needy Unit will enter old bills and non-Medicaid payable-claims.

The first biweekly BSTD or NOSS will be generated on July 16.

Additional Information

Please contact your regional benefit payment administrator if you have any questions.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

September 7, 1999

GENERAL LETTER NO. 8-J-50

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, pages 35 and 85, revised.

Summary

This letter transmits a change in projecting future income for FMAP-related and CMAP-related Medically Needy eligibility determination when an interview has not been held:

- Project future income for initial eligibility determinations using income received in the 30 days before the application date.
- Project future income for recertifications using income received in the 30 days before the date of the recertification request.

These changes are being made due to the elimination of the face-to-face interview as a condition of Medicaid eligibility for persons under age 21. However, there is no change in projecting future income when an interview has been held.

The cost for personal care services in a residential care facility has increased. Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $577.60.

Effective Date

The change in the RCF personal allowance is effective October 1, 1999. Changes on projecting income are effective upon receipt.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, and destroy page 35, dated June 15, 1999, and page 85, dated September 8, 1998.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 7, 1999

GENERAL LETTER NO. 8-J-51

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, pages 19, 25, 26, 53 through 61, 67 through 70, 80, 93, 99, and 100, revised.

Summary

This chapter has been revised to reflect:

- The 1999 Social Security cost of living adjustment (COLA) increase of 2.4%.
- The 1999 Medicare Part A deductible increase.
- Most discount drug plans are not health insurance policies.
- Corrected cross-references.

Effective Date

January 1, 2000

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
19, 25, 26	January 13, 1998
52a	June 15, 1999
53, 54	December 15, 1998
55	January 13, 1998
56-61	December 15, 1998
67	June 15, 1999
68	October 6, 1998
69	December 15, 1998
70	June 15, 1999
80	January 13, 1998
93, 99, 100	June 15, 1999

Additional Information

Please contact your regional benefit payment administrator if you have any questions.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

May 16, 2000

GENERAL LETTER NO. 8-J-52

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***Medically Needy***, Contents (pages 1 and 2), revised; and pages 5, 8, 14, 15, 16, and 67, revised.

Summary

This chapter has been revised to:

- Indicate that the client may choose between the Medically Needy coverage group and Medicaid for employed people with disabilities.
- Indicate that MEPD premiums for a responsible relative are allowed as a deduction from the spenddown amount.
- Eliminate references to the Medically Needy Spenddown Control system and the X-PERT system.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (pages 1 and 2)	June 15, 1999
5, 8	January 13, 1998
14	October 6, 1998
15, 16	June 15, 1999
67	December 7, 1999

Additional Information

Please contact your regional benefit payment administrator if you have additional questions.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

July 11, 2000

GENERAL LETTER NO. 8-J-53

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICAL NEEDY***, pages 2, 5, 12, 19, 21, 23, 31, 32, and 65, revised.

Summary

The following revisions reflect that:

- References to counting resources for children have been removed.
- A child living with nonparental parents can also be included on the Medically Needy case if the child's income exceeds the MAC limit.
- The example on page 23 now indicates that both are under age 21.
- The monthly minimum maintenance needs allowance is updated in the example on page 65.

Effective Date

Upon receipt.

Material Superseded

Remove the following from Employees' Manual, Title 8, Chapter J, and destroy them.

Page	Date
2	January 13, 1998
5	May 16, 2000
12	January 13, 1998
18a	July 15, 1999
19	December 7, 1999
21, 23, 31, 32	January 13, 1998
65	December 15, 1998

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

September 19, 2000

GENERAL LETTER NO. 8-J-54

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICAL NEEDY***, pages 2, 3, 4, 8, 29, 30, 33, 34, 35, 37, 38, 42, 85, and 101 through 103, revised.

Summary

FMAP-related Medically Needy recipients who have a zero spenddown no longer have a six-month certification period. These recipients have ongoing eligibility. They continue to be eligible for Medically Needy as long as their net countable income remains below the MNIL. Review these cases once every 12-months. When their income exceeds the MNIL, assign a two-month certification period. They must reapply at the end of the certification period.

The changes also clarify when resources are counted for FMAP-related Medically Needy eligibility.

The cost for personal care services in a residential care facility has increased. Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $636.58.

Implementation of Ongoing Eligibility for FMAP-Related Cases

Require FMAP-related zero spenddown Medically Needy cases with six month certification periods that end September 30, 2000, to file an application for October because their eligibility ended before October 1, 2000.

Beginning October 1, 2000, FMAP-related persons eligible for Medically Needy with a zero spenddown have ongoing eligibility. These recipients do not need to file an application for ongoing eligibility.

IABC will convert FMAP-related zero spenddown cases from a six-month certification period to ongoing eligibility. The system will do this by extending the certification period for another six-month period.

Certification Ends	Review Date
10/31/00	4/01
11/30/00	5/01
12/31/00	6/01
1/31/01	7/01
2/28/01	8/01
3/31/00	9/01

A letter will be sent to FMAP-related Medically Needy clients with a zero spenddown to inform them that their Medicaid eligibility continues. See **Additional Information** for the text of the letter.

Also at the time of conversion, the system will enter an "S" in the Medicaid CP code on the TD05 screen.

After the conversion has been completed, enter a 12-month certification period for FMAP-related Medically Needy cases that meet the criteria for ongoing eligibility. This currently is done for SSI-related cases.

Enter "S" in the Medicaid CP code on the TD05 screen for these cases. When the case has a 12-month certification period and there is an "S" in the Medicaid CP code on the TD05 screen, the case will not close on the IABC system at the end of the 12-month period. The client has ongoing eligibility.

Use notice reason 344:

> Medical assistance is approved for Medically Needy beginning _____ because you meet all requirements.
>
> EM 8-J Effective Date of Assistance
> 441 IAC 75.1)35)"g" and 76.5(2)"a"

When the income for a FMAP-related Medically Needy ongoing eligibility case exceeds the MNIL, send a timely *Notice of Decision* to the client along with the *Medically Needy Computation Worksheet*. On the IABC system, follow the procedures in 14-I(1), **Case Becomes a Spenddown Case**.

When a FMAP-related Medically Needy case with spenddown becomes an ongoing eligibility case before the two-month certification period ends do the following:

- Change the amount of the spenddown on the ESTD to zero.
- Allow the two month certification period to end. If this occurs before conversion, enter a four-month certification period.
- After the conversion has been completed, enter a ten-month certification period instead of the four-month period. Doing this will ensure that the client is set up for the correct 12-month review date.

When the FMAP related Medically Needy case has ongoing eligibility but has a spenddown for the retroactive certification, follow the procedures on EM 14-I(1), **Approving a Case with Retroactive Period with a Spenddown**. First, enter the retroactive certification period with spenddown. Then enter the ongoing eligibility.

Review the FMAP-related Medically Needy persons at least once every twelve months. At the time of the 12-month review, the case name will appear on the 607 report. Use form 470-2881, *Review/Recertification Eligibility Document*, to complete the review.

Effective Date

October 1, 2000

Material Superseded

Remove the following from Employees' Manual, Title 8, Chapter J, and destroy them.

Page	Date
2	July 11, 2000
3	June 15, 1999
4	January 13, 1998
8	May 16, 2000
29, 30, 33, 34	June 15, 1999
35	September 7, 1999
37	June 15, 1999
38	October 6, 1998
42	June 15, 1999
85	September 7, 1999
101-105	June 15, 1999

Additional Information

The Division of Medical Services is sending a notice with the following text to people who have an FMAP-related Medically Needy case with a zero spenddown:

> Your Medicaid coverage has been changed from a six-month certification period to ongoing eligibility. This notice gives details about the change.
>
> The change affects persons who are on a FMAP-related Medically Needy case and have a zero spenddown. Medicaid will not stop at the end of six-months. Your net countable income must remain below the Medically Needy Income Level (MNIL) and other eligibility requirements must be met. This means that you will not be required to complete an application every six-months.
>
> Your case will be reviewed once every 12-months. Your worker will review your case 12 months from the time that you filed your last application. As a part of the review process, you will be required to complete form PA-2140-0, the *Review/Recertification Eligibility Document*.
>
> Please report these changes to your worker within ten day:
>
> - Income,
> - Health insurance coverage,
> - Who lives at your house, or
> - Address changes.
>
> You may report a change by calling your worker.

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 3, 2000

GENERAL LETTER NO. 8-J-55

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 35 and 85, revised, and page 102, corrected.

Summary

Page 35 is revised to clarify that workers should follow FMAP policy when an FMAP-related Medically Needy person receives a third or fifth check (whether earned income or unearned income).

Pages 85 and 102 are revised to correct typographical errors.

Effective Date

Upon receipt.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, pages 35, 85, and 101, all dated September 19, 2000, and destroy them. (Page 102 was inadvertently omitted from the printed manual.)

Additional Information

Refer questions about this general letter to your regional benefit administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 12, 2000

GENERAL LETTER NO. 8-J-56

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICAL NEEDY***, Contents (page 2), revised; pages 2, 4, 10, 12, 16, 19, 20, 21, 22, 38, 53 through 59, 65 through 74, 80, 93, 95, 98, and 100, revised.

Summary

This chapter has been revised to reflect:

- The 2001 Social Security Cost of Living Adjustment (COLA) increase of 3.5%.
- The 2001 Medicare Part A deductible increase.
- The minimum monthly maintenance allowance for 2001.
- The elimination of deprivation as an FMAP eligibility factor, including:
  - Remove references to deprivation and to update the definition of "dependent child" on page 2.
  - Update the definition of "specified relative" on page 4.
  - Remove the reference to deprivation on pages 12, 20, and 80.
  - Substitute the word "parent" for the word "father" when referring to stepparent on page 16.
  - Remove the reference to deprivation and to change "needy relatives" to "needy specified relatives" on pages 19 and 21.
  - Clarify the example and to remove the reference to deprivation on pages 20, 56, and 98.
  - Clarify when a stepparent is included on page 38.

Pages 10, 67, 73, 74, and 94 are revised to update form numbers.

Effective Date

January 1, 2001

Material Superseded

Remove the following from Employees' Manual, Title 8, Chapter J, and destroy them.

Page	Date
Contents (p. 2)	May 16, 2000
2, 4	September 19, 2000
10	January 13, 1998
12	July 11, 2000
16	May 16, 2000
19	July 11, 2000
20	January 13, 1998
21	July 11, 2000
22	June 15, 1999
38	September 19, 2000
53-59	December 7, 1999
65	July 11, 2000
66	June 15, 1999
67	May 16, 2000
68-70	December 7, 1999
71-74	June 15, 1999
80, 93	December 7, 1999
95, 98	June 15, 1999
100	December 7, 1999

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 13, 2001

GENERAL LETTER NO. 8-J-57

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 1), revised; and pages 17 and 29, revised.

Summary

Page 17 is revised to update an example that includes a reference to the new poverty levels for 2001.

Page 29 and the Table of Contents are revised to correct a typographical error.

Effective Date

April 1, 2001

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them.

Page	Date
Contents (p.1)	May 16, 2000
17	June 19, 1999
29	September 19, 2000

Additional Information

Refer questions about this general letter to your regional benefit administrator.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

July 17, 2001

GENERAL LETTER NO. 8-J-58

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 2), revised; page 68, revised; and page 68a, new.

Summary

This change is to clarify that premiums for certain types of insurance policies may be deducted from the spenddown of Medically Needy recipients.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Table of Contents (page 2)	December 12, 2000
68	December 12, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

August 14, 2001

GENERAL LETTER NO. 8-J-59

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 2), revised; pages 16, 17, 18, 41 through 53, 57, 58, 59, 66, and 70, revised; and page 16a, new.

Summary

Page 16 is revised to include a statement that adult aliens who are ineligible for Medicaid, but are considered people, are included in the household size.

Page 17 and 18 are revised for minor changes.

Page 41 is revised to add that an ineligible alien who is categorically eligible is included in the household size as a "considered' person.

Page 43 is revised to allow an adult who is not eligible for Medicaid due to noncooperation to be a member of the eligible group as a "considered" person.

Examples are updated due to the COLA increase to be received August 1, 2001.

Effective Date

September 1, 2001

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 2)	July 17, 2001
16	December 20, 2000
17	March 13, 2001
18, 41	June 15, 1999
42	September 19, 2000
45	October 6, 1998
46	June 15, 1999
47, 48	January 13, 1998
49	October 6,1998
50, 51	December 15, 1998
52	June 15, 1999
53-55, 57, 58, 59, 66, 70	December 12, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

September 4, 2001

GENERAL LETTER NO. 8-J-60

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, page 85, revised.

Summary

The cost for personal care services in a residential care facility has increased.

Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $704.98.

Effective Date

The change in the RCF personal allowance is effective October 1, 2001.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, page 85, dated October 3, 2000, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 4, 2001

GENERAL LETTER NO. 8-J-61

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 5, 6, 13, 21, 22, 46 through 52, 57, 58, 59, 65, 66, 69, 70, 71, 72, and 93, revised.

Summary

This chapter is revised to reflect the following changes:

- The 2002 Social Security cost of living adjustment (COLA) increase of 2.6%.
- The 2002 Medicare Part A deductible increase.
- The minimum monthly maintenance allowance for 2002.
- The use of form 470-2927 or 470-2927(S), *Health Services Application*, for all Medically Needy applications and recertifications.
- The reference "ABC" system instead of "IABC" system.

Effective Date

January 1, 2002

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
5	July 11, 2000
6, 13	June 15, 1999
21, 22	December 12, 2000
46-52, 57-59	August 14, 2001
65	December 12, 2000
66	August 14, 2001
69	December 12, 2000
70	August 14, 2001
71, 72	December 12, 2000
93	December 12, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 12, 2002

GENERAL LETTER NO. 8-J-62

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 23 and 58, revised.

Summary

This chapter is revised to update examples that include references to poverty levels, due to the new levels for 2002.

Effective Date

April 1, 2002

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
23	July 11, 2000
58	December 4, 2001

Additional Information

Refer questions about this general letter to your service area manager or designee.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

November 19, 2002

GENERAL LETTER NO. 8-J-63

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 22, 38, and 85, revised.

Summary

This general letter:

- Corrects policy for CMAP-related Medically Needy on page 22 by removing activities that no longer apply due to de-linking.
- Corrects an example on page 38.
- Releases an increase in personal care services on page 85. Residents of a licensed RCF are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $727.78.

Effective Date

The change in the RCF personal allowance is effective October 1, 2002.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
22	December 4, 2001
38	December 12, 2000
85	September 4, 2001

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 3, 2002

GENERAL LETTER NO. 8-J-64

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 18, 47 through 52, 57, 58, 59, 66, 69 through 72, and 93, revised.

Summary

This chapter is revised to reflect the following changes:

- The 2003 Social Security cost of living adjustment (COLA) increase of 1.4%.
- The minimum monthly maintenance allowance for 2003.
- The name change of the Medicaid fiscal agent from Consultec to Affiliated Computer Services (ACS).

Effective Date

January 1, 2003

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
18	August 4, 2001
47-52, 57	December 4, 2001
58	March 12, 2002
59, 66, 69-72, 93	December 4, 2001

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 11, 2003

GENERAL LETTER NO. 8-J-65

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, and pages 15, 18, 39, 42, 67, 74, 92, 95, 97, 98, 100, and 102, revised.

Summary

This chapter is revised to:

- Update examples that include a reference to the new poverty levels for 2003.
- Clarify report of change of income.
- Remove references to home-health specified low-income Medicare beneficiaries.
- Change the Medicaid fiscal agent's name from Consultec to ACS.

Effective Date

April 1, 2003

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
15	May 16, 2000
18	December 3, 2002
39	June 15, 1999
42	August 14, 2001
67, 74	December 12, 2000
92	June 15, 1999
95	December 12, 2000
97	June 15, 1999
98, 100	December 12, 2000
102	October 3, 2000

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 16, 2003

GENERAL LETTER NO. 8-J-66

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY*****,** pages 2, 4, 12, 15, 16, 20, 35, 36, 37, 39, 40, 41, 68a, 69, 72, and 85, revised.

Summary

This general letter:

- Adds a definition for the term "categorically" eligible on page 2.
- Makes technical corrections on pages 4, 12, 16, 20, and 72.
- Clarifies income policy to use to project income for FMAP-related Medicaid on page 35.
- Clarifies policy that applies when a stepparent's income is excluded on page 39.
- Clarifies policy for treatment of aliens income and resources on page 41.
- Releases an increase in personal care services on page 85. Residents of a licensed residential care facility (RCF) are allowed a monthly standard deduction for the cost of medically necessary personal care services provided in the RCF to meet spenddown. The amount of the monthly RCF personal care deduction is increased to $746.62.
- References to E-SLMB have been removed as the E-SLMB coverage group has been eliminated.

Effective Date

The change in the RCF personal allowance is effective October 1, 2003.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
2, 4, 12	December 12, 2000
15	March 11, 2003
16	August 14, 2001
20	December 12, 2000
35	October 3, 2000

36	October 6, 1998
37	September 19, 2000
39	March 11, 2003
40	June 15, 1999
41	August 14, 2001
68a	July 17, 2001
69	December 3, 2002
72	December 3, 2002
85	November 19, 2002

Additional Information

Refer questions about this general letter to your income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 9, 2003

GENERAL LETTER NO. 8-J-67

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY,*** pages 47 through 52, 57, 59, 66, 70, 71, and 73, revised.

Summary

This chapter is revised to reflect the following changes:

- The 2004 Social Security cost of living adjustment (COLA) increase of 2.1%.
- The minimum monthly maintenance allowance for 2004.
- To add clarification that providers may still be required to submit a paper claim rather than submitting a claim electronically. This policy is explained in Chapter C of the Medicaid Provider Manual, at the end of the section **Medically Needy Conditional Eligibility**.

Effective Date

January 1, 2004

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
47-52, 57, 59, 66, 70, 71	December 3, 2002
73	December 12, 2000

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

March 23, 2004

GENERAL LETTER NO. 8-J-68

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 17, 23, and 42, revised.

Summary

This chapter is revised to reflect the increase in the federal poverty levels.

Effective Date

April 1, 2004

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
17	August 14, 2001
23	March 12, 2002
42	March 11, 2003

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

May 25, 2004

GENERAL LETTER NO. 8-J-69

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 2, and 79, revised.

Summary

This chapter is revised to:

- Correct the age in the definition of "categorically eligible" for FMAP-related categorically eligible from age 19 to age 18. The definition for FMAP-related categorically eligible now reads: "To be FMAP-related categorically eligible, a person would be a child under age 21, a parent living with a child under age 18, or a pregnant woman."
- Add a note under the "Allowable Medical Expenses for Spenddown" section to specify that the $600 Transitional Assistance portion of the Medicare-Approved Prescription Drug Discount Card Program & $600 Transitional Assistance cannot be used as an allowable medical expense to meet spenddown.

Effective Date

June 1, 2004

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, page 2, dated September 6, 2003 and page 79, dated October 6, 1998, and destroy them.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

August 20, 2004

GENERAL LETTER NO. 8-J-70

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (pages 2 and 3), revised; pages 79, 85, and 86, revised; and pages 86a and 86b, new.

Summary

The Centers for Medicare and Medicaid Services (CMS) has issued revised instructions on how to administer the new Medicare-approved drug discount card and the $600 credit (transitional assistance) for Medically Needy. This General Letter releases those instructions.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides prescription drug benefits to Medicare beneficiaries. Effective January 1, 2006, Medicare beneficiaries will be able to have prescription drug coverage through Medicare, called Medicare Part D. In the interim, from June 1, 2004, through December 31, 2005, Medicare beneficiaries who do not receive Medicaid can:

- Purchase a Medicare-approved discount drug card and
- Certain beneficiaries can receive a $600 credit (transitional assistance), in 2004 and up to another $600 credit in 2005 to help pay for prescription drugs.

Receipt of these additional Medicare benefits cannot adversely affect other federal benefits. This means receipt of a credit or a discount due to these Medicare benefits cannot cause a delay in the receipt of Medicaid benefits.

Therefore, the Centers for Medicare and Medicaid Services (CMS) has issued new guidance on how to handle the Medicare–approved drug discount card and the $600 credit. Prescription drugs purchased with the $600 credit will be allowed toward meeting spenddown. Additionally, the pre-discount cost of drugs will be allowed toward meeting spenddown.

Implementation

Ask conditionally eligible Medically Needy recipients if they have been approved for the $600 prescription credit or a Medicare-approved discount drug card.

If the person **has not been approved** for either of the new benefits but is interested in finding out more about them, advise the person that:

- The person should have received information from the Social Security Administration about the benefits. For more information, refer the person to:
  - The Social Security Administration toll-free number, 1-800–MEDICARE (633-4227); or
  - The Social Security Administration web site at www.medicare.gov (select "Prescription Drug and Other Assistance Programs"); or
  - The Senior Health Insurance Information Program (SHIIP) at 1-800-351-4664.
- If the person has already met spenddown and is eligible for Medicaid, the person needs to apply for the Medicare benefits at the beginning of a certification period when the person has not met spenddown.

If the person **has been approved** for the $600 prescription drug credit or the Medicare-approved discount drug card, ask clients if they purchased drugs with the credit or received the discount since that date. If yes, advise clients about the change of policy and allow them to submit bills for this period.

Additionally, the DHS SPIRS Help Desk issued a message July 15, 2004, regarding this change. The message instructed staff to keep a list of clients who reported receipt of the Medicare Approved Drug Discount Card or the $600 credit. Notify clients on your list of this change and advise them to provide receipts for drugs purchased with the credit. Establish the pre-discount costs for all drugs purchased with the discount card. Submit to ACS.

Procedures

The pharmacy will charge a discounted price for the drug. When using these benefits toward spenddown:

- Treat the pre-discount cost of the drug paid by the $600 credit as an incurred medical expense and apply to the spenddown. The $600 credit does not have to be used before Medicaid payment of medical expenses, including prescription drugs. Pharmacies will not be submitting claims for prescriptions to meet spenddown when the prescription is paid for by the $600 credit.
- If a prescription purchase is discounted through use of the Medicare-approved drug discount card, use the pre-discount amount toward spenddown.
- Allow the cost of the Medicare-approved discount card as an insurance deduction.

The only way these prescription costs can be applied to meet spenddown is by the client supplying receipts as proof of the purchase. Instruct clients to provide receipts for the purchase of prescription drugs to you for processing.

Use one of these methods to determine the pre-discount price of the drug:

- Check the receipt, as the pre-discount amount may be on the receipt.
- Use receipts for the same drug purchased before the person enrolled for a Medicare-approved drug discount card.
- Contact the pharmacy to determine the pre-discount price.

If you cannot determine the actual pre-discount price of a prescription drug, allow $48.17 (per prescription) as a substitute for the pre-discount drug price. This amount represents the national average cost per prescription for the cash-paying customer in 2003 based on CMS' Office of the Actuary analysis of data from IMS Health, National Prescription Audit for 2003. The $48.17 represents the full cost of the drug when you cannot verify the pre-discount cost of the drug. If the verified discounted cost of the drug is higher than $48.17, use the higher, verified amount.

A fee of up to $30 per year may be charged for the Medicare-approved discount drug card. Any documented fee paid by the Medicaid spenddown client for a Medicare-approved discount drug card must be treated as an incurred medical expense and deducted from the client's spenddown amount when determining the spenddown amount to be entered on TD05.

Note: Do not allow the deduction if the fee for the Medicare-approved discount drug card is paid by the federal or state government, rather than by the client.

Drug Discount Card

Deduct a prorated amount of the documented cost of the Medicare-Approved Drug Discount card from the spenddown amount, the same as you currently do for other insurance premiums.

$600 Credit and Discount Amount Due to Use of Drug Discount Card

Use form 470-3630, *Medically Needy Transmittal*, to send claims to ACS to be entered on the MN subsystem to meet spenddown. When sending receipts for the $600 credit purchases and purchases with the drug discount card, include the pre-discount cost.

For all prescriptions, include:

- The national drug code (NDC). The pharmacy can provide this number.
- The provider number or provider name and address.

Effective Date

Upon receipt, retroactive to June 1, 2004.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 2)	August 14, 2001
Contents (page 3)	June15, 1999
79	May 25, 2004
85	September 16, 2004
86	January 13, 1998

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 17, 2004

GENERAL LETTER NO. 8-J-71

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, page 86a, revised.

Summary

This general letter releases:

- An increase in the deduction amount for personal care services. Residents of a licensed residential care facility (RCF) are allowed a monthly standard deduction to meet spenddown for the cost of medically necessary personal care services provided in the RCF. The amount of the monthly RCF personal care deduction is increased to $804.69.
- An additional instruction for submitting claims to ACS under the Medicare-approved drug discount card or credit provisions. When completing form 470-3630, *Medically Needy Transmittal*, write "non-standard claim" in the "Comments" section. This will alert ACS that special processing is required.

Effective Date

October 1, 2004

Material Superseded

Remove page 86a, dated August 20, 2004, from Employees' Manual, Title 8, Chapter J, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 10, 2004

GENERAL LETTER NO. 8-J-72

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 2), revised; and pages 45 through 60, 66, 70, 71, 85, and 86, revised.

Summary

This chapter is revised to reflect the following changes:

- The 2005 Social Security cost-of-living-adjustment (COLA) increase of 2.7%.
- The minimum monthly maintenance allowance for 2005.
- Issue revised instructions for submitting prescription drug purchases made with the Medicare-approved drug discount card or the $600 credit. Rather than have all claims for purchases made with the discount card or credit processed through the local office, pharmacies will submit the claims to ACS, unless there is a problem.

  If a problem occurs and the pharmacy is unable to submit the claims, then the claims will need to be submitted through the local office.

Effective Date

January 1, 2005

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 2)	August 20, 2004
45	August 14, 2001
46	December 4, 2001
47-52	December 9, 2003
53	August 14, 2001
56	December 12, 2000
57	December 9, 2003
58	December 3, 2002
59	December 9, 2003
60, 61	December 7, 1999

62	October 6, 1998
66, 70, 71	December 9, 2003
85, 86	August 20, 2004

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 23, 2005

GENERAL LETTER NO. 8-J-73

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 3, 49 through 58, 67, 72, 73, 74, 81, 82, 84, 85, 86, 86a, 92, 93, 95, 96, 97, 100, 101, and 102, revised.

Summary

This chapter is revised to reflect the following changes:

- The amount of the medical expense deduction for RCF personal care services is increased to $830.53 per month. The personal care services per diem rate is increased to $27.32.
- *Medically Needy Transmittals*, form 470-3630, can now be faxed or mailed to the IME Medically Needy Unit.
- References to ACS and the fiscal agent have been changed to the IME.
- References to the use of bills from the state papers program are removed from the chapter. The state papers program ended effective June 30, 2005.

Effective Date

October 1, 2005

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
3	September 19, 2000
49-58	December 10, 2004
67	March 11, 2003
72	September 16, 2003
73	December 9, 2003
74	March 11, 2003
81	January 13, 1998
82, 84	June 15, 1999

85, 86	December 10, 2004
86a	September 17, 2004
92	March 11, 2003
93	December 3, 2003
95	March 11, 2002
96	June 15, 1999
97, 100	March 11, 2002
101	September 19, 2000
102	March 11, 2002

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

November 25, 2005

GENERAL LETTER NO. 8-J-74

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 6, 13, 14, 46 through 54, 65, 66, 69, 70, and 71, revised.

Summary

This chapter is revised to:

- Change the form used for Medically Needy recertifications from form 470-2927 or 470-2927(S), *Health Services Application*, to form 470-3118 or 470-118(S), *Medicaid Review*.
- Change the examples in this chapter to reflect the following:
  - The 2006 Social Security cost-of-living-adjustment (COLA) increase of 4.1%.
  - The minimum monthly maintenance needs allowance for 2006.
  - The new Medicare rate of $88.50.
  - The correct MEPD income amount.
- Remove language on MHI residents aged 22 through 64 under the section, "Who Is Not Eligible for Medically Needy," since this group is now eligible for Medicaid benefits and is excluded from Medically Needy eligibility on that basis.
- Change procedure for requesting a manual buy-in from the IME Policy Unit.

Effective Date

The new *Medicaid Review* form is effective for reviews initiated after December 1, 2005, except for FMAP-related households with a spenddown, who will continue to complete the system-generated RRED until a system-generated version of the new review form is available.

The 2006 COLA increase, the minimum monthly maintenance needs allowance, and the new Medicare rate of $88.50 are effective January 1, 2006.

All other changes are effective immediately.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
6, 13	December 4, 2001
14	May 16, 2000
46-48	December 10, 2004
49-54	September 23, 2005
65	December 4, 2001
66	December 10, 2004
69	September 16, 2003
70-71	December 10, 2004

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 30, 2005

GENERAL LETTER NO. 8-J-75

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (pages 2 and 3), revised; pages 86a and 86b, revised; and pages 86c and 86d, new.

Summary

This chapter is revised to incorporate information about Medicare Part D and address how the costs associated with Part D are treated for spenddown cases.

Effective Date

January 1, 2006

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 2)	December 10, 2004
Contents (page 3)	August 20, 2004
86a	September 23, 2005
86b	August 20, 2004

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

February 24, 2006

GENERAL LETTER NO. 8-J-76

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (pages 1, 2, and 3), revised; and pages 15, 16, 16a, 68a, 69, and 86a through 86d, revised.

Summary

This chapter is revised to:

- Clarify that expanded specified low-income Medicare beneficiaries (E-SLMB) may also be determined conditionally eligible for Medically Needy.
- Update and clarify the procedures to follow when processing Medicare Part D expenses for Medically Needy spenddown cases based on the federal clarification from CMS.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 1)	August 20, 2004
Contents (pages 2, 3)	December 30, 2005
15, 16	September 16, 2003
16a	August 14, 2001
68a	September 16, 2003
69	November 25, 2005
86a-86d	December 30, 2005

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

April 21, 2006

GENERAL LETTER NO. 8-J-77

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 49, 51, and 57, revised.

Summary

This chapter is revised to correct two SSI-related examples and one page with incorrect information on the amount to deem to ineligible children.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
49, 51	November 25, 2005
57	September 23, 2005

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 15, 2006

GENERAL LETTER NO. 8-J-78

ISSUED BY: Bureau of Medical Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (pages 2 and 3), revised, and pages 37, 85, 86, 86a, and 86b, revised.

Summary

This chapter is revised to reflect the following changes:

- The amount of the medical expenses deduction for RCF personal care expense is decreased to $813.50. The personal care services per diem is decreased to $26.76.
- The form used for FMAP-related Medically Needy recertifications is changed from form 470-2881, *Review/Recertification Eligibility Document,* to form 470-3118 or 470-3118(S), *Medicaid Review*.
- The section on deductions for the Medicaid drug discount card and credit is removed, since this program has ended.

Effective Date

The RCF deduction change is effective October 1, 2006. The other changes are already in effect.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (pp. 2, 3)	February 24, 2006
37	September 16, 2003
85, 86	September 23, 2005
86a-86d	February 24, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

May 11, 2007

GENERAL LETTER NO. 8-J-80

ISSUED BY: Bureau of Medical Supports, Division of Health, Financial and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 1), revised; pages 13, 23 through 32, 41, 51, 71, 79, 98, and 100 through 103, revised.

Summary

This chapter is revised to:

- Change examples to reflect the following:
  - Increase in income to make the eligibility determination of the example correct.
  - Removal of the need to verify pregnancy.
  - Removal of the reference to Medicare-approved Drug Discount Card and $600 credit.
  - Clarification that Medicare Part D premiums are paid by Extra Help for Medicare Part D.
- Add a CMAP-related Medicaid example.
- Clarify resource policy.
- Correct the amount of income for calculating the needs of each child in an SSI-related home.
- Refer the IM worker to 8-G, "Reporting Changes," for changes that need to be reported.
- Tell the IM worker to act on any changes reported on other program report forms.
- Correct cross-references and form names where appropriate.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 1)	February 24, 2006
13	November 25, 2005
23	March 23, 2004
24	January 13, 1998
25, 26	December 7, 1999
27, 28	January 13, 1998
29	March 13, 2001
30	September 19, 2000
31, 32	July 11, 2000
41	September 16, 2003
51, 71	December 1, 2006
79	August 20, 2004
98	March 11, 2003
100-102	September 23, 2005
103	September 19, 2000

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

August 3, 2007

GENERAL LETTER NO. 8-J-81

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 5 through 8, 19 through 22, 24, 34, 35, 37, 44, 46, 47, 67, 69, 73, 77, and 84, revised.

Summary

This chapter is revised to:

- Eliminate the requirement for an interview.
- Change the earned income deduction from 50% to 58%.
- Change postpartum policy under Medically Needy to match FMAP-related policies.
- Removes references to the *Medical Assistance Card.*

Effective Date

Effective August 1, 2007, eliminate the requirement for an interview and change the earned income deduction from 50% to 58%.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
5	December 4, 2001
6	November 25, 2005
7	January 13, 1998
8	September 19, 2000
19	December 12, 2000
20	September 16, 2003
21	December 4, 2001
22	November 19, 2002
24	May 11, 2007

34	September 19, 2000
35	September 16, 2003
37	September 15, 2006
44	August 14, 2001
46	November 25, 2005
47	December 1, 2006
67	September 23, 2005
69	February 24, 2006
73	September 23, 2005
77	June 15, 1999
84	September 23, 2005

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 21, 2007

GENERAL LETTER NO. 8-J-82

ISSUED BY: Bureau of Medical Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 23, 24, and 86a, revised.

Summary

This chapter is revised to:

- Allow newborn status for children born to women who apply and obtain Medicaid for the month of the birth, including three-day emergency services, even when the application was filed after the birth.
- Increase the amount of the medical expense deduction for RCF personal care services to $844.51. The personal care services per diem is increased to $27.78.

Effective Date

October 1, 2007

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
23	May 11, 2007
24	August 3, 2007
86a	September 15, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

February 1, 2008

GENERAL LETTER NO. 8-J-83

ISSUED BY: Bureau of Medical Supports, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, Contents (page 3), revised; pages 5, 27, 29, 49 through 57, 66, 69, 70, 71, 93, and 94, revised.

Summary

This chapter is revised to change the examples in this chapter to reflect the following:

- The 2008 Social Security cost-of-living-adjustment (COLA) increase of 2.3%.
- The minimum monthly maintenance needs allowance for 2008.
- The new Medicare Part B rate of $93.50.
- The increase in the Part A and Part B deductible for 2008.
- The change of the name of form 470-2340, 470-2340(S), 470-0364, and 470-0364(S), from *Medicaid Information Questionnaire for SSI Persons* to *SSI Medicaid Information*.
- The addition of form 470-4459 and 470-4459(S), *Authorization to Disclose Information to the Department of Human Services*.

Effective Date

January 1, 2008

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
Contents (page 3)	September 15, 2006
5	August 3, 2007
27, 29	May 11, 2007
49, 50	December 1, 2006

51	May 11, 2007
52-57, 66	December 1, 2006
69	August 3, 2007
70	December 1, 2006
71	May 11, 2007
93, 94	December 1, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

October 10, 2008

GENERAL LETTER NO. 8-J-84

ISSUED BY: Bureau of Medical Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, page 86a, revised.

Summary

This chapter is revised to decrease the amount of the medical expenses deduction for residential care facility (RCF) personal care services from $844.51 to $762.74. The personal care services per diem rate decreased from $27.78 to $25.09.

Effective Date

November 1, 2008

Material Superseded

Remove from Employees' Manual, Title 8, Chapter J, page 86a, dated September 21, 2007, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

December 5, 2008

GENERAL LETTER NO. 8-J-85

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter J, ***MEDICALLY NEEDY***, pages 41 through 58, 65, 66, 74, and 93, revised.

Summary

This chapter is revised to reflect the following:

- The 2009 Social Security cost-of-living-adjustment (COLA) increase of 5.8%.
- The minimum monthly maintenance needs allowance for 2009.
- The increase in the Part A deductible for 2009.
- Clarification of when to do a one-month certification period and a two-month certification period for aliens receiving three days of emergency service.
- SSI policies followed to determine the amount of income to deem.

Note: The Medicare Part B premium and deductible amount for 2009 is the same as 2008.

Effective Date

January 1, 2009

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter J, and destroy them:

Page	Date
41	May 11, 2007
42	March 23, 2004
43	August 14, 2001
44	August 3, 2007
45	November 22, 2004
46, 47	August 3, 2007

48	December 1, 2006
49-58	February 1, 2008
65	December 1, 2006
66	February 1, 2008
74	September 23, 2005
93	February 1, 2008

Additional Information

Refer questions about this general letter to your area income maintenance administrator.